



External Quality Review (EQR) Annual Technical Report

MO HealthNet

March 2026

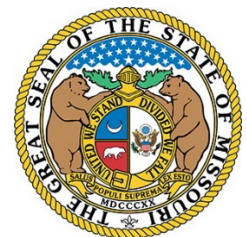
Review Period 2024

Presented by:

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As Missouri's Medicaid external quality review organization (EQRO), Comagine Health provides external quality review (EQR) and supports quality improvement for enrollees of Missouri HealthNet (MO HealthNet) managed care programs.

Comagine Health prepared this report under contract with Missouri Department of Social Services MO HealthNet Division to conduct EQR and quality improvement activities to meet Code of Federal Regulation (CFR) - 42 CFR §438, Managed Care, Subpart C, External Quality Review.

Comagine Health is a national, nonprofit health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvement in the health care system. Comagine Health is a seasoned EQRO contractor with more than 25 years of experience in evaluation and review activities, including experience in reviewing managed care entities against the Centers for Medicare & Medicaid Services (CMS) EQR Protocols, CFRs and state compliance with contracts requirements. For more information, visit us online at www.comagine.org.

MetaStar is based in Madison, Wisconsin, and has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 50 years, and represents Wisconsin in the Superior Health Quality Alliance, under the CMS Quality Improvement Organization Program. MetaStar is an EQRO contractor for more than 50 years with experience in both mandatory and optional activities outlined in the CMS EQR protocols. For more information, visit www.metastar.com.

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Acronym List

Table 1 below shows the list of acronyms used in this report.

Table 1. Acronyms Used Frequently in this Report.

Acronym	Definition
AEG	Adult Expansion Group
AI	Artificial Intelligence
API	Application Programming Interface
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CC	Care Coordination
CCBHO	Community Care Behavioral Health Organization
CEAC	Counties with Extreme Access Considerations
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CL	Closure
CM	Care Management
CMs	Care Managers
CMS	Centers for Medicare & Medicaid Services
CP	Care Planning
CY	Calendar Year
DCN	Department Client Number
DM	Disease Management
DSS	Department of Social Services
DYS	Division of Youth Services
EA	Enrollment and Assessment
EHR	Electronic Health Record
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Final Audit Report
FPL	Federal Poverty Level
FUH	Follow-Up After Hospitalization
FUH30	Follow-Up After Hospitalization Within 30 Days
HB	Healthy Blue
HEDIS ^{®1}	Healthcare Effectiveness Data and Information Set
HMO	Health Maintenance Organization
HSB	Home State Health
IHCP	Indian Health Care Providers
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
LTSS	Long Term Services and Support

¹ The Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a registered trademark of NCQA.

Acronym	Definition
MCO	Managed Care Organization
MCP	Managed Care Plan
MHD	MO HealthNet Division
MSR	Medicaid State Rate
NA	Not Applicable
NAV	Network Adequacy Validation
NCQA	National Committee for Quality Assurance
NOP	Notice of Pregnancy
NQS	National Quality Strategy
OB/GYN	Obstetrician-Gynecologist
OIG	Office of Inspector General
OT	Occupational Therapist
P2P	Peer-To-Peer
PA	Prior Authorization
PAHP	Prepaid Ambulatory Health Plan
PCN	Children's Mercy Primary Care Network
PDSA	Plan Do Study Act
PCP	Primary Care Provider
PT	Physical Therapist
PDSA	Plan Do Study Act
PSYCH	Psychiatrist
PIHP	Pre-Paid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
PPVS	Post Provider Visit Surveys
PROMs	Patient-reported Outcome Measures
QAPI	Quality Assurance and Performance Improvement
QIS	Quality Improvement Strategy
RA	Required Actions
REDCap	Research Electronic Data Capture
SMHB	Show-Me Healthy Babies
SMHK	Show Me Healthy Kids
ST	Speech Therapist
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
ST	Speech Therapist
UHC	UnitedHealthcare Community Plan of Missouri
WIC	Women, Infants and Children

Executive Summary

This executive summary presents the key findings from the External Quality Review (EQR) Annual Technical Report for Missouri Managed Care Plan (MCPs). Comagine Health, serving as the State's contracted External Quality Review Organization (EQRO), conducted its review in calendar year 2025 (CY2025) of MCP performance during CY2024.

This summary highlights how the MCPs are performing and includes areas where improvement is needed. It is intended to give state agencies, MCP leaders, providers, policymakers and managed care enrollees a clear picture of overall system performance and to support ongoing efforts to improve the quality of care in the MO Healthnet Division (MHD) program.

Summary of EQR Activities

The federal regulations governing EQR under 42 (Code of Federal Regulations) CFR Part 438 outline both mandatory and optional activities that must be addressed by the EQRO. The CY2025 EQR conducted included activities that align with the Centers for Medicare & Medicaid Services (CMS) protocols² follow.

Quality Improvement Strategy (QIS) Effectiveness Analysis

Comagine Health's review of Missouri's QIS highlights strengths in managed care and identifies opportunities to enhance care for enrollees while promoting efficiency and collaboration. Missouri's QIS is robust, providing a comprehensive framework that drives measurable improvements in quality, timeliness and accessibility of health care services. Notable progress from the prior year was observed in digital interoperability, resiliency planning, person-centered engagement, and the use of scientific and technological advancements, though further improvement is still needed. The EQRO recommends continued expansion of digital interoperability, strengthening resiliency planning, deepening person-centered engagement, and advancing safety-oriented initiatives to build on the previous gains. Please refer to the [Quality Improvement Strategy \(QIS\) Effectiveness Analysis](#) section for additional details.

Performance Improvement Project (PIP) Validation

The EQRO found that Missouri's MCPs are making progress in improving member satisfaction, access to care and service delivery, with strengths in digital tools, member engagement and provider feedback. The MCPs aggregately received a high confidence rating of 96.7% for Validation Rating 1, which assessed adherence to methodology. However, Comagine Health identified inconsistencies in study quality across the MCPs. These issues included weak sampling, limited control groups and data challenges that lowered confidence in the methodology related findings.

MCPs received an aggregate no-confidence rating of 64.7% for Validation Rating 2, which evaluated evidence of significant improvement. Overall, stated aims were often not met, and even when meaningful or statistically significant improvements occurred, the observed gains were generally not attributed to the selected interventions.

To address these issues, required actions and recommendations were provided to strengthen evaluation methods, improve sampling and analytic techniques, and ensure that future intervention strategies can be confidently linked to measurable improvements in performance. Please refer to the [Performance Improvement Project \(PIP\) Validation](#) section for additional details.

² Electronic Code of Federal Regulations. Available at: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1>

Performance Measure Validation (PMV)

Between measurement years 2023 and 2024, Missouri's Medicaid State Rate (MSR) showed statistically significant improvements in several key areas, including well-care/well-child visits, adolescent immunizations, lead screening, blood pressure control and follow-up after hospitalization for mental illness. These gains reflect meaningful progress in preventive care and chronic condition management. MCPs are encouraged to sustain and expand these efforts. At the same time, declines were observed in the asthma medication ratio and chlamydia screening rates, highlighting the need for MCPs to identify barriers and strengthen strategies to improve performance in these critical measures. Please refer to the [Performance Measure Validation \(PMV\)](#) section for additional details.

Compliance with Standards Review (Compliance)

MCPs demonstrated strong performance in several key areas of the grievance system, including general requirements, timely and adequate notice of adverse benefit determination, and handling of grievances and appeals. In addition, the MCPs scored 100% for the information about the grievance and appeal system to providers and subcontractors, and recordkeeping standards.

Notable deficiencies were observed in the areas of compliance with grievance and appeal system requirements, resolution and notification processes, expedited resolution of appeals, and continuation of benefits during pending appeals and state Fair Hearings, which all fell below the 90% threshold. These gaps highlight the need for targeted corrective actions to ensure members receive timely and consistent care under federal standards. Please refer to the [Compliance with Standards Review](#) section for additional details.

Network Adequacy Validation (NAV)

Overall, the network adequacy standards review and validation results for the MCPs and MO—which reflects the overall aggregate program-level—indicate a very comprehensive provider network. Collectively, the MCPs achieved an aggregate score of 95.6% for the provider network indicators. These results highlight strong performance across all plans. The MCPs received an aggregate validation score of 94.4% and a rating of “High Confidence” for all provider network indicators, underscoring the reliability and robustness of the evaluation process.

No improvements were recommended for monitoring processes. The EQRO does recommend that MHD work with MCPs to address unmet access standards by identifying root causes such as provider shortages or contracting issues and offer technical assistance as needed. Please refer to the [Network Adequacy Validation \(NAV\)](#) section for additional details.

Information System Capabilities Assessment (ISCA)

To support its ISCA, Comagine Health received the final audit reports (FARs) from the MCPs and reviewed them to determine and develop EQR findings and recommendations. These results offer an independent evaluation of the MCPs' information systems. The FARs confirmed the MCPs met all standards of the ISCA. No recommendations, strengths or weaknesses were noted during the CY2025 ISCA review. Please refer to the [Information System Capabilities Assessment \(ISCA\)](#) section for additional details.

Focus Studies

In CY2025, the following focus studies were performed by Comagine Health.

Care Management (CM) Program Review

Across the MCPs, CM is member centered. The document review showed strengths in care planning and care coordination. However, the three MCPs reviewed in Focus Area 1 (Multiple Comorbid Conditions) and Focus Area 2 (Pregnancy/Obstetrics) require updated policies, revised procedures and staff training to ensure consistent enrollment and assessment practices. The two MCPs evaluated for the disease management (DM) “opt out methodology” scored 0.0% on the clinical review, indicating a critical compliance gap. Closure processes also raised concerns and call for further review to ensure requirements are met. Review of Focus Area 3 (Foster Care) results indicated assessments occurred timely and care plans were comprehensive. The MCP delivering these services should focus on providing clearer evidence of coordination and follow-up in the records, as well as offering DM in a timely manner. Please refer to the [Care Management \(CM\) Review](#) section for additional details.

Prior Authorization (PA) Audit Program Review

All audit records were submitted within the timeframe outlined during MCP orientation. The consistent, timely delivery of complete documentation, along with the MCPs’ responsiveness to requests for additional information, demonstrates strong operational efficiency, preparedness and accountability across MCPs.

All MCPs exhibited a solid grasp of the exclusion criteria. Despite this overall competency, there were notable instances where medical records were initially submitted in error requiring resubmission after confirmation that inclusion criteria were not satisfied. Such occurrences suggest that while the criteria are generally well understood, there were gaps in internal review processes or documentation verification practices prior to submission.

Routine cases, *without requests* for additional information, were managed within the required 36-hour timeframe for three of the four MCPs. Urgent cases, *without requests* for additional information, were infrequent. All MCPs processed these cases within the contracted 24-hour timeframe.

All MCPs met the standards in Focus Areas 2 (Selection and Application of Medical Necessity Criteria/Clinical Guidelines) and 3 (Rationale in Denial Determination); however, not all MCPs achieved the required thresholds in Focus Area 1 (Timeliness Standards). Recommendations for MHD in these areas included reviewing and amending contract provisions, and providing technical assistance for data mapping (Focus area 1); establishing a standardized approach to administrative denials (Focus area 2); and consideration of key findings and recommendations provided in the July 2023 report by the Office of Inspector General (OIG) [Focus Area 3]. Please refer to the [Prior Authorization \(PA\) Audit Program](#) section for additional details.

Secret Shopper Survey

The Secret Shopper study found that all MCPs exceeded the target for primary care and psychiatric providers accepting new patients, demonstrating strong network availability. However, none of the MCPs met the required thresholds for timely appointment scheduling across routine, urgent and post-discharge care. In addition, Comagine Health evaluated the accuracy of each MCP’s provider directory for primary care providers, specifically assessing whether listings included a correct phone number, office address and accurate patient acceptance status. While there was no numeric directory accuracy threshold for the CY2025 measurement year, all MCPs demonstrated poor performance. These findings underscore the need for MCPs to expand appointment capacity, improve scheduling timeliness and strengthen directory accuracy through verification processes, clearer specialty classifications and the use of technology or third-party validation services. Please refer to the [Secret Shopper Survey](#) for additional details.

Introduction

Objective

Federal requirements under 42 CFR Part 438 mandate that every state Medicaid agency that contracts with MCPs provide for an EQR of health care furnished to Medicaid enrollees. The federal requirements outline both mandatory and optional activities that must be addressed through the review. No MCPs in Missouri are exempt from the EQR.

This annual technical report presents the findings for services reviewed during the 2025 EQR, calendar year 2025 (CY2025) and summarizes MCP activities occurring from Jan. 1 through Dec. 31, 2024. Data aggregation and analysis related to these services are presented as outlined below.

- Validation of Performance Improvement Projects (PIPs)
- Validation of Performance Measures (PMV)
- Review of Compliance with Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations (Compliance)
- Validation of Network Adequacy (NAV)
- Focus Studies
 - Care Management (CM)
 - Prior Authorization Audit Program (PA)
 - Secret Shopper Survey (Secret Shopper)
- Information System Capabilities Assessment (ISCA)

In addition to these activities, Comagine Health provides the following:

- Feedback to inform and support Missouri's Quality Improvement Strategy (QIS) and oversight of each MCP's Quality Assessment and Performance Improvement (QAPI) program
- Follow up on the previous year's EQRO recommendations for all activities reported in the [2024 EQR Annual Technical Report](#).

Missouri Medicaid Program

The mission of the Missouri Department of Social Services (DSS) is to "Empower Missourians to live safe, healthy and productive lives." DSS is responsible for administering the MO HealthNet Division (MHD) program, formerly known as the Missouri Medicaid Program.

MHD's purpose, through DSS, is to purchase and monitor health care services for low income and vulnerable citizens of the state of Missouri. MHD assures quality health care through development of service delivery systems, standards setting and enforcement and education of MHD providers and participants.

The DSS MHD Managed Care Program delivers services to individuals through a 1915(b) Waiver that allows the managed care system to provide Medicaid services to Section 1931 children and related poverty-level populations, Section 1931 adults and related poverty populations, including pregnant women, CHIP children and foster care children.

Missouri's CHIP was a Medicaid expansion implemented on Sept. 1, 1998, through a waiver under Section 1115 of the Social Security Act. Missouri's CHIP State Child Health Plan uses funds provided

under Title XXI to both expand eligibility under Missouri's State Medicaid Plan and to obtain coverage that meets the requirements for a separate child health program.

A constitutional amendment was passed in August 2020, requiring the state to offer services to adults ages 19-64 with income up to 138% of the federal poverty level. These adults began receiving services through the managed care system Oct. 1, 2021, under Section 1932(a), known as the Adult Expansion Group.

Effective July 1, 2022, the MHD Managed Care Program awarded a Specialty Plan, known as Show Me Healthy Kids, to provide integrated care for State Care and Custody children. Show Me Health Kids was established to provide a trauma-informed comprehensive and integrated behavioral health/physical health delivery system allowing these children and youth to grow into healthy adults and live full and satisfying lives.

In Missouri, Medicaid beneficiaries are covered by four MCPs. As of December 2024, there were 1,010,206 individuals enrolled in MHD, Managed Care.

Healthy Blue (HB)

HB is a Medicaid product offered by Missouri Care, Inc. which oversees its administration in Missouri and collaboratively manages services in the Kansas City region with Blue Cross and Blue Shield of Kansas City. Both Missouri Care, Inc., and Blue Cross and Blue Shield of Kansas City are independent licensees of the Blue Cross Blue Shield Association.

As of December 2024, HB served 351,168 Medicaid enrollees. Their mission is to provide members with the necessary coverage while ensuring they understand how to use and maintain their benefits. HB maintains consistent accreditation from the National Committee for Quality Assurance (NCQA).

Home State Health (HSH) and Show Me Healthy Kids (SMHK)

HSH is a wholly owned subsidiary of Centene Corporation, and operates with a vision to transform the health of the community, one person at a time. HSH delivers coordinated, holistic, integrated and high-quality services to Medicaid beneficiaries across the state of Missouri.

SMHK is a specialty plan managed by HSH. SMHK's vision is to transform the health of the community one person at a time. Starting in July 2022, SMHK began delivering coordinated, holistic, integrated and high-quality services to Missouri children in care and custody.

As of December 2024, HSH served 313,233 Medicaid enrollees, while SMHK served 41,719 Medicaid enrollees. HSH holds an NCQA accreditation.

UnitedHealthcare Community Plan of Missouri (UHC)

UHC's vision is to empower members to reach their full health potential through a sustainable care ecosystem that delivers equitable care whenever and wherever they need it. As of December 2024, UHC served 304,086 Medicaid enrollees.

UHC has achieved NCQA Health Plan and Health Equity accreditations, in addition to obtaining National Credentialing and Utilization Management accreditation through NCQA.

Evaluation of Quality, Access and Timeliness of Health Care and Services

Under 42 Code of Federal Regulation (CFR) §438.364, states are required to contract with a qualified EQRO to summarize findings from each EQR-related activity, where data is aggregated and analyzed. Conclusions are drawn regarding the quality, timeliness and access to health care provided by MCPs to Medicaid beneficiaries.



Quality

Quality of care includes access and timeliness, the processes used to deliver care and the patient experience. Enrollee outcomes can indicate quality, but they are influenced by many factors outside a provider's control, such as patient adherence to treatment. CMS defines quality as how well a managed care organization (MCO) increases the likelihood of good health outcomes for its enrollees by using effective organizational structures and operations, and by providing care that follows current professional standards.

Access

Access to care involves the steps people take to obtain needed health services and describes their experience before care begins. It influences both patient experience and health outcomes and therefore affects overall quality of care. Adequate access depends on factors such as appointment availability, the ability to see specialists, the strength of the provider network, and the availability of transportation and translation services.

Timeliness

Timeliness of care reflects the readiness with which enrollees are able to access care, a factor that ultimately influences quality of care and patient outcomes. It also reflects the health plan's adherence to timelines related to authorization of services, payment of claims, and processing of grievances and appeals.

As shown in Table 2, Comagine Health's EQR is based on these same performance themes.

Table 2. Evaluation of Health Care Services by Performance Theme.

Quality	Access	Timeliness
- Care Management - Compliance - Performance Improvement Project - Performance Measure Validation - Quality Strategy Analysis	- Care Management - Compliance - Network Adequacy Validation - Performance Improvement Project - Performance Measure Validation - Prior Authorization - Quality Strategy Analysis - Secret Shopper Survey	- Care Management - Compliance - Network Adequacy Validation - Performance Improvement Project - Performance Measure Validation - Prior Authorization - Quality Strategy Analysis - Secret Shopper Survey

Medicaid MCP Enrollment

In Missouri, the following individuals are covered and receive their services under the MHD Managed Care Program:³

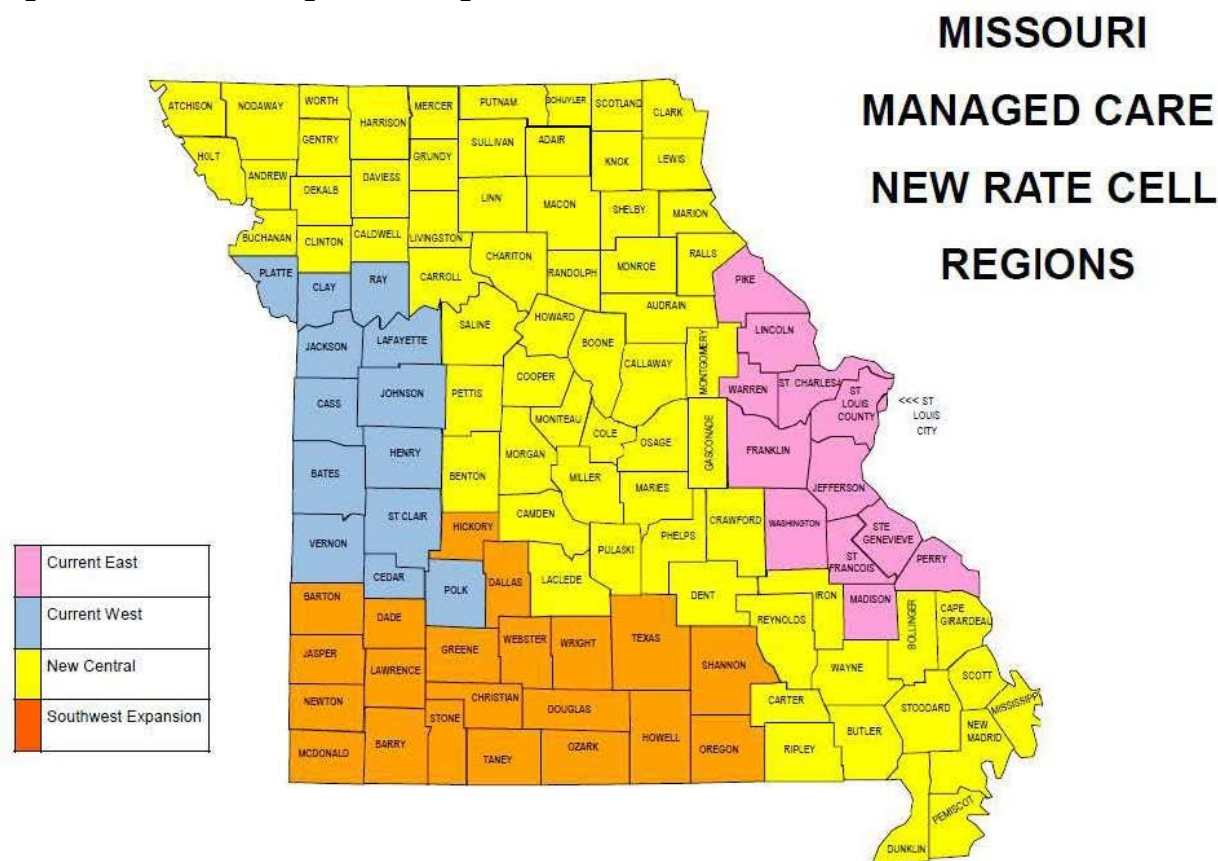
- **Parents and Caretakers, Children, Newborns** – Individuals covered under the MHD Managed Care Program within this group are as follows:
 - **MO HealthNet for Families**
 - MO HealthNet for Families – Adult
 - MO HealthNet for Families – Children
 - **MO HealthNet for Kids – Poverty**
 - MO HealthNet for Kids – Poverty
 - MO HealthNet for Kids – Health Initiative Fund
 - **Newborns**
 - Newborns (Eligibility Only)
- **Pregnant Women** – Individuals covered under the MHD Managed Care Program within this group are as follows:
 - **MO HealthNet for Pregnant Women**
 - MO HealthNet for Pregnant Women
 - Pregnant Women – 12 month postpartum – Medical Assistance for Families
 - **Pregnant Women – 60 days Poverty**
 - Pregnant Women – Poverty
 - Pregnant Woman Poverty 133% – 185% Federal Poverty Level (FPL) – Healthcare for Uninsured Families
 - Show-Me Healthy Babies (SMHB) Pregnant Women – Income above 196% and up to 300% FPL
 - SMHB Unborn Child income 0% to 300% FPL
 - SMHB Postpartum
- **MO HealthNet Children in Care and Custody and Adoption Subsidy (SMHK Population)** – Individuals covered under the MHD Managed Care Program within this group are as follows:
 - **Department of Social Services Division of Family Services**
 - Title IV-E Foster Care Program
 - Title XIX Federal Financial Participation Hearing Disabled Newborns
 - Independent Foster Care Children – Age 18 up to Age 26
 - Child Welfare Services – Foster Care
 - Child Welfare – Healthcare for Uninsured Families
 - **Adoption Subsidy**
 - Adoption Subsidy – Title IV - E Eligible
 - Adoption Subsidy – Federal Financial Participation

³ Missouri DSS. MO HealthNet Managed Care Eligibility Groups. Available at: <https://mydss.mo.gov/media/pdf/mo-healthnet-managed-care-eligibility-groups>.

- Adoption Subsidy – Child Welfare Services
- **Division of Youth Services (DYS)**
 - DYS – Family and Youth Services – Foster Care
 - DYS – General Revenue
 - DYS – Poverty
 - DYS – Healthcare for Uninsured Families
- **State Children’s Health Insurance Program (CHIP)**
 - CHIP 134-150% FPL – Age 1-5
 - CHIP 101-150% FPL – Age 6-18
 - CHIP 151-185% FPL – Age 1-18
 - CHIP 186-225% FPL – Age 0-18
 - CHIP 226-300% FPL – Age 0-18
 - SMHB Newborns
- **Adult Expansion Group (AEG)** – Individuals covered under the MHD Managed Care Program within this group are as follows:
 - Non-disabled adults aged 19-64 with incomes up to 138% FPL

Figure 1 shows MHD Managed Care operations in the following regions of the state of Missouri:

- **East:** Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis County, Warren and Washington counties and St. Louis City.
- **West:** Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair and Vernon counties.
- **Central:** Adair, Andrew, Atchison, Audrain, Benton, Bollinger, Boone, Buchanan, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Carter, Chariton, Clark, Clinton, Cole, Cooper, Crawford, Daviess, DeKalb, Dent, Dunklin, Gasconade, Gentry, Grundy, Harrison, Holt, Howard, Iron, Knox, Laclede, Lewis, Linn, Livingston, Macon, Maries, Marion, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Nodaway, Osage, Pemiscot, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, Stoddard, Sullivan, Wayne and Worth counties.
- **Southwest:** Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster and Wright counties.

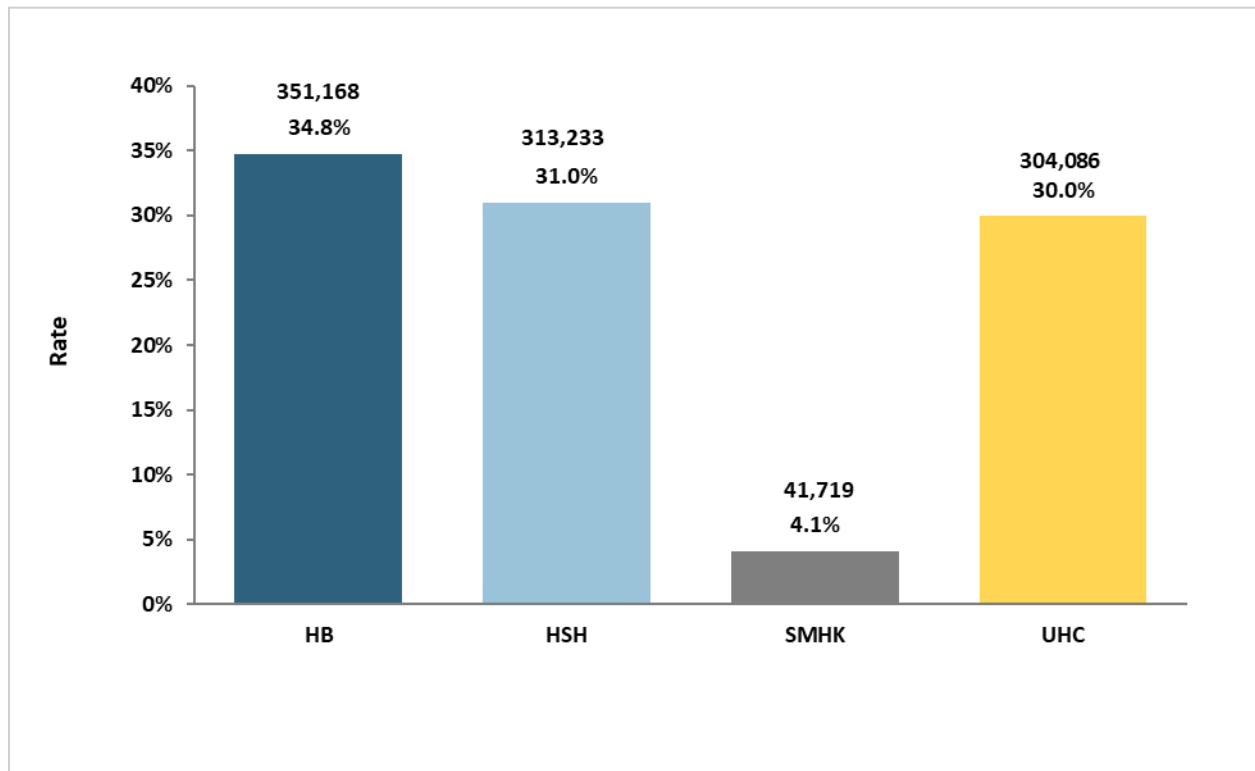
Figure 1. Missouri Managed Care Regions.⁴

MO HealthNet Enrollment

In 2025, the four MCPs provided managed health care services for Medicaid beneficiaries who meet the eligibility requirements.

Figure 2 shows MCP Medicaid enrollment by MCP. HB represents the largest share at 34.8%, followed by HSH at 31.0%, UHC at 30.0% and SMHK at 4.1%, which makes up the smallest portion.

⁴ Missouri DSS. Regions Map and the MO HealthNet Managed Care Health Plans. Available at: <https://mydss.mo.gov/media/pdf/regions-map-and-mo-healthnet-managed-care-health-plans-each-region>.

Figure 2. Percent of Total State Medicaid Enrollment, by MCP.

Quality Improvement Strategy (QIS) Effectiveness Analysis

Objective

Missouri's Managed Care Quality Improvement Strategy (QIS) is a comprehensive strategy to assess, monitor and coordinate the quality of the managed care services, and develop measurable goals and targets for continuous quality improvement.

The EQR is one part of an interrelated set of quality requirements that apply to Medicaid managed care. Feedback provided by the EQRO is reviewed when MHD updates the QIS. Per §§438.364(a)(4) and 457.1250, the feedback obtained from the state's EQRO should be used by states when examining and updating the quality strategy. The QIS is implemented through the ongoing comprehensive QAPI program that each MCP is required to establish for the services provided to members. The PIPs and performance measures included in the QAPIs are validated through the annual EQR.

Along with the summary of quality, access and timeliness established under §438.364, the EQR incorporates the CMS National Quality Strategy (NQS) into its evaluation framework of the QIS, utilizing it as a benchmark to align state-level quality initiatives with national priorities. The NQS provides a robust structure for promoting equity, health outcomes and system resilience across care settings, making it particularly suited to addressing the needs of Medicaid populations. By leveraging NQS priorities and measures, MHD can enhance transparency, equity and accountability in its QIS, ensuring alignment with federal guidelines and broader quality improvement efforts.

Overview

MHD's QIS focuses on monitoring, evaluation and improvement of care delivery. The Managed Care Program aims to provide effective high-quality services, ensure the satisfaction of members and involve stakeholders while achieving cost efficiencies for the state. Since the last quality strategy update in 2024, the state's Medicaid landscape has undergone significant changes. These include revised PIP requirements, updated EQR PMV, the addition of child and adult core set measures, and implementation of the EQR Prior Authorization Audit Development and Activity program. Missouri has also upgraded its network access software and in partnership with the EQRO launched the Network Adequacy Validation activity to strengthen oversight of provider-reported network data and provider availability. Together, these enhancements provide more flexible monitoring options and improved transparency and ensure timely access to care with enhanced data and frequency. The performance withhold program was updated with slightly increased evaluation criteria beginning in state fiscal year 2024.

Additionally, Missouri has successfully implemented a new beneficiary support system enabling participants to pay premiums online, improving access to care. CMS approved a 1915(b) waiver in early 2024 for Missouri to begin the Transformation of Rural Community Health project which directs resources to rural communities. Missouri launched an initiative focused on improving maternal and infant outcomes, resulting in several key changes. The state secured approval for a State Plan Amendment extending comprehensive coverage after pregnancy through Medicaid and CHIP for postpartum individuals for 12 months, initiated the Notification of Pregnancy Project and developed the Healthy Birthweight Incentive Program and the Prenatal Care Adequacy Index Program. These changes aim to improve health care access, quality and timeliness.

The QIS is developed collaboratively, ensuring compliance with federal and state requirements. The QIS undergoes a review and public comment process, allowing for the incorporation of feedback. Revision of the QIS occurs every three years or as necessary, based on evaluation outcomes or major program changes. All QIS documents and updates are publicly available for transparency and accountability.

An annual effectiveness review is conducted by Missouri's EQRO. The MHD review and updating of the QIS takes into account recommendations from the EQRO for improving the quality of health care services furnished by each MCP, including how MHD can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness and access to health care services furnished to MCP members. The most recent revision of the QIS Strategy was conducted by MHD in 2024 and incorporated feedback from the previously contracted EQRO in 2021. MHD integrates QIS monitoring into the ongoing quality oversight activities throughout each year. This continuous engagement allows MHD to regularly assess progress toward QIS goals and make timely adjustments, as needed. MHD conducts a formal review and reflection of QIS progress each year in alignment with key reporting cycles, including preparation for the Annual Technical Report to ensure alignment with the overall quality strategy and compliance with federal requirements.

MHD evaluates progress in meeting its quality strategy goals through:

- Regular audits and reviews of the MCPs' compliance with contract requirements
- Regular collection and analysis of MCP performance metrics and data
- Monitoring of MCP required action plans
- Active engagement throughout the EQR process

Quality Strategy Populations and Programs

The QIS is applicable to the MHD-contracted managed care offerings provided through four managed care health plans and special focused programs including:

- CHIP
- Former Foster Care Youth
- Show-Me Healthy Babies
- MHD Foster Care Specialty Plan – SMHK
- Adult Expansion Group (AEG)

The QIS is not applicable to Medicaid fee-for-service.

Quality Strategy Mission and Vision

The QIS mission and vision provide the overall framework that informs MHD's strategy to address access to care, wellness and prevention, outcomes, cost-effective utilization of services and customer satisfaction. The vision and mission for the QIS align well with the four aims of the NQS particularly by demonstrating a commitment to health equity, focusing on measurable outcomes and an emphasis on whole-person, patient-centered care.

MO HealthNet Managed Care Program Goals and Objectives

At a high level, the QIS goals relate to quality, access and timeliness of care. The QIS provides four goals that ensure Missouri managed care enrollees receive the appropriate, responsive and evidence-based health care. The four QIS goals are shown below in Table 3.

The QIS objectives further expand on the approach that MHD will take to provide oversight to ensure that the managed care program is accountable to achieving outcomes for each goal. Additionally, the QIS outlines process mechanisms created to monitor and support improvement activities on a continual basis such as the Quality Data Review Committee, Quality Assessment and Improvement Advisory Group.

CMS National Quality Strategy Priority Areas and Goals

The CMS National Quality Strategy⁵ has four priority areas, each with two goals. See below for key excerpts from the strategy.

NQS 1: Promote Aligned and Improved Health Outcomes – Ensures coordination in identifying high-priority outcomes across the Agency and in implementing quality reporting and value-based programs and policies that address these priorities:

- Goal 1 – Outcomes: Improve Quality and Health Outcomes Across the Care Journey
- Goal 2 – Alignment: Align and Coordinate Across Programs and Care Settings

NQS 2: Advance Equity and Engagement for All Individuals – Advances health equity and ensures the voices of individuals, families and caregivers are valued and directly contribute to how CMS evaluates the impact of its programs on equity, safety and quality.

- Goal 1 – Equity: Advance Health Equity and Whole-Person Care
- Goal 2 – Engagement: Engage Individuals and Communities to Become Partners in Their Care

NQS 3: Ensure Safe and Resilient Health Care Systems – Advances CMS' renewed commitment to enabling a deeply embedded safety culture and ensuring the health care ecosystem has tools and solutions for achieving safer routine care while maintaining high safety levels in times of crisis.

- Goal 1 – Safety: Achieve Zero Preventable Harm
- Goal 2 – Resiliency: Enable a Responsive and Resilient Health Care System to Improve Quality

NQS 4: Accelerate Interoperability and Scientific Innovation – The Interoperability and Scientific Advancement priority area recognizes that improved data practices support advanced analytics, rapid-cycle feedback and aligned quality measurement strategies that can lead to continuous improvement in person-centered care.

- Goal 1 – Interoperability: Accelerate and Support the Transition to a Digital and Data-Driven Health Care System
- Goal 2 – Scientific Advancement: Transform Health Care using Science, Analytics and Technology

The MHD QIS goals and CMS NQS Priority Areas are represented in a crosswalk, in Table 3, further illustrating how the QIS goals are aligned with the national framework.

⁵ CMS National Quality Strategy. Available at: <https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy>

Table 3. MHD QIS Goals and CMS National Quality Strategy Priority Areas Crosswalk.

MHD Quality Improvement Strategy*	Alignment with CMS NQS Priority Areas and Domains
QIS 1: Ensure appropriate access to care for the state’s Managed Care population by monitoring appointment standards and network adequacy.	NQS 1, NQS 2 Access, Timeliness
QIS 2: Promote the health and wellness of Managed Care members through use of preventative services.	NQS 2, NQS 3 Quality, Access
QIS 3: Ensure cost-effective utilization of services.	NQS 1, NQS 2, NQS 3, NQS 4 Quality, Access, Timeliness
QIS 4: Promote member satisfaction with experience of care.	NQS 1, NQS 2 Quality, Access, Timeliness

*State of Missouri Managed Care Quality Strategy – October 2024.⁶

Quality Strategy Evaluation

To support MHD in the continued efforts to improve managed care in the state of Missouri, Comagine Health conducts an annual review of the state’s QIS and provides an assessment of the strengths and recommendations of the strategy in place.

Information and Documentation Reviewed

To better support the quality, timeliness and access to health care services provided to MCP enrollees, Comagine Health has reviewed the following information and activities to assist with targeting goals and objectives in the Quality Strategy:

- CMS National Quality Strategy
- Quality in Motion: Acting on the CMS NQS; April 2024
- CMS’s Cross Cutting Initiative Fact Sheet; November 2024⁷
- 2024 State of Missouri Managed Care QIS
- 2025 Evaluation of the 2024 State of Missouri Managed Care QIS
- All EQRO activity results, including:
 - Performance Improvement Project Validation
 - Performance Measure Validation
 - Compliance with Standards Review
 - Network Adequacy Validation
 - Care Management Review (focus study)
 - Prior Authorization Audit Program (focus study)
 - Secret Shopper Survey (focus study)

⁶ State of Missouri Managed Care Quality Strategy – October 2024. Available at: <https://mydss.mo.gov/media/pdf/2024-quality-improvement-strategy-0>

⁷ CMS Cross Cutting Initiative Fact Sheet; November 2024; <https://www.cms.gov/files/document/final-cci-national-quality-strategy-fact-sheet.pdf>

2025 Strengths

In addition to the strengths of the QIS established in the inaugural year of the Quality Strategy, Comagine Health acknowledges the significant efforts put forth by MHD over the past year to improve the QIS. Table 4 shares strengths found during the 2025 EQR of the QIS.

Table 4. 2025 Strengths Related to the Quality Strategy.

Strengths	Linked to QIS Goal(s)*	Domain(s)
Increase Digital Interoperability: MHD's commitment to public-facing dashboards and enhanced reporting for Prior Authorization metrics is a clear strength, as is its alignment with CMS's Application Programming Interface (API) requirements.	Goals 1, 3	Quality Access Timeliness
Improve Resiliency Planning: MHD's review of disaster recovery plans and contract language is a strong step toward embedding system resilience. The drafted QIS language is comprehensive and aligns well with emergency preparedness standards.	Goals 2, 4	Access Timeliness
Enhance Integration of Person-Centered Engagement: MHD's implementation of tools such as the Notice of Pregnancy (NOP) portal and risk screening tool reflects meaningful progress toward person-centered engagement. The use of multiple advisory bodies and the formation of an internal quality/clinical team to overhaul care and disease management programs signal a broader shift toward embedding person-centeredness across operational and strategic priorities.	Goals 2, 3, 4	Quality Access
Integrate Scientific and Technological Advancements: MHD's active monitoring of national trends in artificial intelligence (AI) and predictive analytics, engagement with MCPs and exploration of vendor partnerships reflect a thoughtful and forward-looking approach to innovation. As this is an emerging area, continued exploration and deliberate implementation of predictive analytics and AI technologies will be key. Ensuring that future adoption is equitable, evidence-informed and aligned with population health goals will help maximize impact.	Goals 2, 3, 4	Quality Access Timeliness

Progress on 2024 Recommendations and 2025 Recommendations

On an annual basis, Comagine Health evaluates progress on the previous year's EQRO recommendations and provides additional recommendations for continued progress. Table 5 outlines the recommendations included in the CY2024 EQR annual technical report, MHD's follow-up on recommendations and the EQRO Response to MHD's progress.

Table 5 presents new CY2025 EQR recommendations for MHD aimed at driving continuous improvement in strengthening the QIS. These recommendations are intended to help align goals and objectives within the QIS to enhance the quality, timeliness and accessibility of health care services.

Table 5. 2024 EQRO Recommendations, MHD Response and EQRO Response.

EQRO Recommendation
Increase Digital Interoperability: The QIS strategy lacks explicit measures or structures to support digital interoperability. In contrast, the NQS and 2024 CMS Final Rule prioritizes interoperability and digital transition to improve care coordination and accessibility of health records.
MHD Response
MHD remains committed to advancing digital interoperability in alignment with CMS’s Interoperability and Patient Access Rule. Current initiatives include the development and maintenance of public-facing dashboards (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS], Healthcare Effectiveness Data and Information Set [HEDIS], Provider Network Adequacy, Prior Authorization) to enhance transparency and facilitate informed decision-making. MHD has advanced focus on digital reporting by including electronic measures in our Performance Withhold Program. MHD has implemented new annual reporting requirements for Prior Authorization metrics based on CMS guidelines and will create a new dashboard by March 31, 2026, in compliance with CMS requirements of 42 CFR 438.210(f). MHD is working with the MCP’s to help prepare them to meet Prior Authorization API requirements being implemented by CMS effective January 2027. Efforts to support the MCPs include leveraging information from MCP API dashboards and updating MHD/MCP contract language to require an attestation of compliance with CFR API requirements. MHD continues to collaborate with the MCPs to ensure PA metric data will be available for reporting.
EQRO Response
MHD’s commitment to public-facing dashboards and utilization of existing data reporting platforms is a clear strength and in alignment with CMS’s API requirements. MHD could make additional progress by explicitly addressing digital interoperability beyond reporting. There is a clear opportunity to enhance data sharing capabilities by strengthening secure exchange protocols, standardizing interoperability documentation practices, improving system availability and ensuring consistency across Patient Access, Provider Access, Payer-to-Payer and Prior Authorization API standards across platforms. These elements are critical to achieving true interoperability and aligning with the broader goals of the CMS Interoperability and Patient Access Rule.
EQRO Recommendation
Improve Resiliency Planning: In contrast to the NQS’s focus on system resilience for emergency responses and climate-related events, the QIS strategy does not explicitly address health system resilience. This could be a critical gap during public health crises or extreme weather events and could worsen long-term threats to the health care system, such as workforce issues.
MHD Response
MHD has conducted a comprehensive review of managed care contract language and MCP disaster recovery plans to ensure that emergency preparedness protocols are not only compliant but also robust. Language has been drafted for future QIS updates to further embed system reliance and crisis response into MHD’s strategic framework. Drafted language to include in the next QIS:
Health System Resilience
MHD is committed to maintaining services during emergencies, including public health crises and extreme weather events. The Managed Care contract requires all health plans to have policies and procedures to address crisis situations, including those related to weather, natural disasters and shutdowns. During a declared major disaster, all health plans’ core eligibility and enrollment and claims processing systems must be back online within 72 hours of the disaster’s occurrence. In addition, health plans must have a disaster recovery plan to ensure member access to information and services

in events of a declared emergency, natural disaster, inclement weather, system failures and system disruptions. The current health plans' disaster recovery plans cover these requirements and include plans for a loss of 50% personnel, evacuation plans and specific contacts for various emergencies. These requirements ensure participants are still able to access services.

EQRO Response

MHD's review of disaster recovery plans and managed care contract language is a strong foundation for embedding system resilience. The draft QIS language reflects a clear commitment to maintaining services during emergencies and aligns well with emergency preparedness standards. Requirements for system restoration timelines, personnel loss contingencies and member access protocols are important components of operational continuity.

To address the concept of health system resilience more fully, MHD could consider expanding its approach beyond business continuity for MCP operations. Specifically, incorporating expectations for MCPs to actively support member needs before, during and after emergency events would strengthen alignment with the NQS's focus on system-wide preparedness. This could include proactive outreach to high-risk members ahead of anticipated emergencies (e.g., heat waves, storms, etc.), ensuring continuity of care for individuals dependent on life-sustaining treatments and facilitating emergency medication access for displaced members.

Additionally, referencing a defined Business Continuity Plan alongside the Disaster Recovery framework and establishing routine testing protocols, such as tabletop exercises or failover simulations, would further reinforce MHD's commitment to operational resiliency and member-centered emergency response.

MHD's implementation of tools such as the NOP portal and risk screening tool reflects meaningful progress toward person-centered engagement. The use of multiple advisory bodies and the formation of an internal quality/clinical team to overhaul Care and DM Programs signal a broader shift toward embedding person-centeredness across operational and strategic priorities.

To further strengthen alignment with the NQS, MHD could consider expanding its efforts to include patient-reported outcome measures (PROMs) and mechanisms that enable members to access their own health records. These elements are critical to empowering individuals in their care journey, particularly for those seeking culturally competent services. Continued updates on the quality/clinical team's work will be important to understanding how these initiatives evolve and contribute to improved member experience and health outcomes.

EQRO Recommendation

Enhance Integration of Person-Centered Engagement: The NQS emphasizes active engagement with individuals and communities to improve satisfaction and experience, but the QIS has limited person-reported outcome measures or initiatives to increase patients' access to their own health records. This may be particularly relevant for members accessing culturally competent care and ensuring viable mechanisms for gaining true access to that care.

MHD Response

MHD continues to elevate person-centered strategies through the implementation of tools such as the NOP portal and accompanying risk screening tool – initiatives that have enhanced timely identification of member needs and access to care coordination services. MHD utilizes multiple advisory bodies to ensure the voice of the member is reflected in planning and quality improvement activities.

Additionally, an internal quality/clinical team has formed to overhaul our Care Management and DM Program with focus on population health. This will ensure all members are informed and aware of mechanisms for gaining access to care and increasing their knowledge including self-management of their specific condition(s), resulting in improved health outcomes. These efforts signal MHD's broader shift toward embedding person-centeredness across operational and strategic priorities.

EQRO Response

MHD's implementation of tools such as the NOP portal and risk screening tool reflects meaningful progress toward person-centered engagement. The use of multiple advisory bodies and the formation of an internal quality/clinical team to overhaul Care and DM Programs signal a broader shift toward embedding person-centeredness across operational and strategic priorities.

To further strengthen alignment with the NQS, MHD could consider expanding its efforts to include PROMs and mechanisms that enable members to access their own health records. These elements are critical to empowering individuals in their care journey, particularly for those seeking culturally competent services. Continued updates on the quality/clinical team's work will be important to understanding how these initiatives evolve and contribute to improved member experience and health outcomes.

EQRO Recommendation

Increase Safety-Oriented Initiatives: The QIS omits any explicit discussion of safety, which is a major pillar of the NQS framework. The QIS would benefit from incorporation of zero-preventable-harm initiatives such as enhanced safety protocols, tracking and public reporting of safety events and promotion of a holistic systems-based safety focus.

MHD Response

MHD is working to integrate patient safety as a strategic priority by reviewing opportunities to embed Zero Preventable Harm principles within quality frameworks, contract requirements and oversight mechanisms. Current actions include analysis of provider preventable conditions reports, review of MCP quality assurance and performance improvement (QAPI) and contract language exploration. MHD recognizes the importance of proactive safety management in improving outcomes and member experience.

EQRO Response

MHD's efforts to integrate patient safety as a strategic priority are conceptually aligned with the NQS framework. The review of provider preventable conditions reports, MCP QAPI submissions and contract language exploration reflects an important foundation for embedding Zero Preventable Harm principles.

To strengthen this approach, MHD could provide greater specificity regarding the contract requirements and oversight mechanisms under consideration. While the current response signals intent, more detailed articulation of how safety protocols will be operationalized, such as through public reporting of safety events, standardized tracking systems and/or systems-based safety training, would clarify the scope and impact of these initiatives.

Additionally, revisiting earlier recommendations around enhanced safety protocols, holistic systems-based safety strategies and transparent reporting mechanisms remain relevant. These elements are essential to advancing a culture of safety and aligning with the broader goals of the NQS and national patient safety efforts.

EQRO Recommendation

Integrate Scientific and Technological Advancements: The NQS includes goals for advancing analytics and AI, which the QIS currently does not integrate. Embracing predictive analytics and innovative technologies could enhance the QIS strategy in areas like prior authorization, population health and predictive care models.

MHD Response

MHD is actively monitoring national trends in AI and predictive analysis to better understand their utility in advancing care coordination, utilization management and operational efficiencies.

Conversations are underway with MCPs to assess readiness and ensure future technological advancements are implemented in a deliberate, equitable and evidence-informed manner. The MHD is also exploring partnerships and viewing demos of vendors who can assist with predictive analytics to inform decision making and increase cost savings through population health focused initiatives.

EQRO Response

MHD's proactive engagement with emerging technologies, including predictive analytics and AI, is a strong indicator of its commitment to innovation. Monitoring national trends, assessing MCP readiness and exploring vendor partnerships are appropriate and timely steps, given the evolving nature of these tools.

As this is a rapidly developing area, continued exploration and deliberate implementation will be key. Ensuring that future adoption is equitable, evidence-informed and aligned with population health goals will help maximize the impact of these technologies. While the field is still maturing, MHD's current approach reflects thoughtful leadership and positions the agency well to leverage scientific and technological advancements in support of care coordination, utilization management and strategic planning.

Table 6. 2025 Recommendations Related to the Quality Strategy.

Recommendations	Linked to QIS Goal(s)*	Domains
Increase Digital Interoperability: Additional progress by MHD can be made by more explicitly addressing digital interoperability beyond reporting. Specifically, there's an opportunity to expand on data sharing capabilities, including secure exchange protocols, standardized interoperability documentation practices, system availability and consistency in Patient Access, Provider Access, Payer-to-Payer and Prior Authorization API standards across platforms.	Goals 1, 3	Quality Access Timeliness
Improve Resiliency Planning: Additional progress toward resiliency planning could be made by explicitly referencing a defined Business Continuity Plan to complement the Disaster Recovery Framework and establishing routine testing protocols such as tabletop exercises or system failover simulations which would help ensure operational resiliency during actual disruptions. Further, expanding the scope beyond MCP business continuity to include member-focused emergency support, such as outreach to high-risk patients and emergency medication access, would better align with the broader goals of health system resilience.	Goals 2, 4	Access Timeliness
Enhance Integration of Person-Centered Engagement: Additional progress could be made by expanding efforts to include PROMs and mechanisms that enable members to access their own health records. These elements are critical to empowering individuals in their care journey, particularly for those seeking culturally competent services.	Goals 2, 3, 4	Quality Access Timeliness
Increase Safety-Oriented Initiatives: Additional progress could be made by providing greater specificity regarding contract requirements and oversight mechanisms under consideration. Further, operationalizing safety protocols through public reporting of safety events, standardized tracking systems, and systems-based safety training	Goals 2, 3, 4	Quality Access

Recommendations	Linked to QIS Goal(s)*	Domains
would clarify the scope and impact of these initiatives. Revisiting earlier recommendations around enhanced safety protocols, holistic systems-based safety strategies and transparent reporting mechanisms remains relevant to advancing a culture of safety.		

**Goals from State of Missouri Managed Care Quality Strategy – October 2024.*

Please see additional program level recommendations made to MHD to improve MCP performance in the following sections of this Annual Technical Report. Below are the QIS goals that align with the MHD program level recommendations.

- Performance Improvement Project Validation (Goals 2, 3, 4)
- Performance Measure Validation (Goals 2, 3)
- Compliance with Standards Review (Goals 3, 4)
- Network Adequacy Validation (Goals 1, 3, 4)
- Care Management Review (Goals 2, 3, 4)
- Prior Authorization Audits (Goals 2, 3, 4)
- Secret Shopper Survey (Goals 1, 4)

Performance Improvement Project (PIP) Validation

Objective

As part of the quality assessment and performance improvement program mandated by §438.330(b)(1) and 457.1240(b), Missouri MCPs must carry out PIPs annually. These requirements are also specified in sections 2.19.9(d) and 3.15.6 of the MHD MCP contract.

Overview



A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee experience. A PIP may be designed to change behavior at a member, provider and/or MCP/system level and are aimed at enhancing both clinical and nonclinical aspects within the plan. In Missouri, all MCP PIPs were implemented on a statewide basis.

Validation of PIPs is a required EQR activity described at §438.358(b)(1)(i). The intent of the PIP validation process is to ensure the PIPs contain sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that it has a comprehensive and logical thread that ties each aspect (e.g., aim statement, sampling methodology and data collection) together.

Comagine Health conducted an assessment and validation to ensure the PIPs were designed, implemented, analyzed and reported in a methodologically sound manner.

This section describes the PIPs conducted in CY2024, referred to as measure year (MY) 2024 in this section and submitted for validation in CY2025.

Methodology

As required under *CMS Protocol 1. Validation of Performance Improvement Projects (PIPs)*, Comagine Health determined whether PIP validation criteria were “Met,” “Partially Met” or “Not Met.” In addition, Comagine Health utilizes validation ratings in reporting the results of the MCPs’ PIPs.

Scoring

Each standard has a specified number of scoring elements, which correlate to the PIP validation worksheets. Element score results are presented as either “Yes,” “No” or “Not Applicable (NA)” based on the reviewer’s evaluation of the MCP’s responses and documents submitted. Elements scored NA are not reviewed and are not included in the final scoring. Standard scores are presented as the number of “Yes” elements out of the total number of scoring elements possible for each validation rating.

For a full description of the methodology, please see [Appendix A: PIP Validation Methodology](#).

Summary of PIP Validation Results

PIP Validation Ratings

The “validation ratings” refer to the overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results and produced evidence of significant improvement. Comagine Health provides two validation ratings of the PIP results:

- Validation Rating 1: Overall confidence that the PIP adhered to acceptable methodology for all phases.
- Validation Rating 2: Overall confidence that the PIP produced evidence of significant improvement.

Table 7, Table 8 and Table 9 provide the scoring legend, summary of all MCP PIP validation ratings, overall scores and an aggregate overall rating and score at the program level (MO).⁸

Table 7. MO PIP Validation Rating and Overall Scoring Legend.

Percentage of Validation Steps Met	Validation Rating (Confidence Level)	Overall Score
90% – 100%	High confidence in reported results	Met
80% – 89.9%	Moderate confidence in reported results	Partially Met
70% – 79.9%	Low confidence in reported results	Not Met
≤ 69.9%	No confidence in reported results	Not Met

Table 8. PIP Validation Rating 1 – MCPs and MO.

Plan	PIP	Scoring Elements	% Score	Validation Rating
HB	Inpatient Re-Admissions for Mental Health	47/48	97.9%	High Confidence
HB	Improving Member Satisfaction	50/50	100%	High Confidence
HSH	Inpatient Re-Admissions for Mental Health	37/39	94.9%	High Confidence
HSH	Improving Member Satisfaction	48/50	96.0%	High Confidence
SMHK	Inpatient Re-Admissions for Mental Health	42/43	97.7%	High Confidence
SMHK	Improving Member Satisfaction	39/44	88.6%	Moderate Confidence
UHC	Inpatient Re-Admissions for Mental Health	44/44	100%	High Confidence
UHC	Improving Member Satisfaction	45/46	97.8%	High Confidence
MO	Overall PIP Program Level – Validation Rating 1	352/364	96.7%	High Confidence

Table 9. PIP Validation Rating 2 – MCPs and MO.

Plan	PIP	Scoring Elements	% Score	Validation Rating
HB	Inpatient Re-Admissions for Mental Health	4/7	57.1%	No Confidence
HB	Improving Member Satisfaction	6/7	85.7%	Moderate Confidence
HSH	Inpatient Re-Admissions for Mental Health	5/7	71.4%	Low Confidence
HSH	Improving Member Satisfaction	2/5	40.0%	No Confidence
SMHK	Inpatient Re-Admissions for Mental Health	5/7	71.4%	Low Confidence
SMHK	Improving Member Satisfaction	5/7	71.4%	Low Confidence
UHC	Inpatient Re-Admissions for Mental Health	4/6	66.7%	No Confidence
UHC	Improving Member Satisfaction	2/5	40.0%	No Confidence
MO	Overall PIP Program Level – Validation Rating 2	33/51	64.7%	No Confidence

⁸ Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive scores.

Overall PIP Score

The overall PIP score is based on the nine individual validation standard scores. The overall score is presented as the total number of “Yes” results out of the number of scoring elements possible for each of the nine individual validation standard scores.

Table 10 shows the overall score summary for each MCP’s PIPs and the overall score at the program level (MO).

Table 10. PIP Summary – MCPs and MO

Plan	PIP	Validation Rating 1	Validation Rating 2	Scoring Elements	Overall Score %	Overall Score
HB	Inpatient Re-Admissions for Mental Health	97.9%	57.1%	51/55	92.7%	Met
HB	Improving Member Satisfaction	100%	85.7%	56/57	98.2%	Met
HSH	Inpatient Re-Admissions for Mental Health	94.9%	71.4%	42/46	91.3%	Met
HSH	Improving Member Satisfaction	96.0%	40.0%	50/55	90.9%	Met
SMHK	Inpatient Re-Admissions for Mental Health	97.7%	71.4%	47/50	94.0%	Met
SMHK	Improving Member Satisfaction	88.6%	71.4%	44/51	86.3%	Partially Met
UHC	Inpatient Re-Admissions for Mental Health	100%	66.7%	48/50	96.0%	Met
UHC	Improving Member Satisfaction	97.8%	40.0%	47/51	92.2%	Met
MO	Overall PIP Program Level Score	96.7%	64.7%	385/415	92.8%	Met

Program Level PIP EQRO Recommendations

Based on the program level findings from the PIP validation, weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation to MHD.

- **Validation Rating 2** – Overall confidence that the PIP produced evidence of significant improvement (64.7%)
 - One of the four MCPS, for a total of one of the eight PIPs validated, received a rating of moderate confidence.
 - Three of the four MCPS, for a total of three of the eight PIPs validated, received a rating of low confidence.
 - Three of the four MCPS, for a total of four of the eight PIPs validated, received a rating of no confidence.

The MCPs did not meet all elements for the following standards. The MCPs will benefit from technical assistance by MHD to ensure the plans meet these requirements. PIPs are required to meet this element as part of the validation process.

- Three of the four MCPs, for a total of three of the eight PIPs validated, did not conduct analyses that accounted for factors that could have threatened the internal or external validity of the findings (**Standard 7**).

- Two of the four MCPs, for a total of four of the eight PIPs validated, did not implement strategies designed to account for or adjust for any major confounding variables that could have obvious impact on the PIPs outcomes (**Standard 8**).
- Three of the four MCPs, for a total of three of the eight PIPs validated, did not achieve the goals outlined in the aim statement (**Standard 9**).
- Three of the four MCPs, for a total of six of the eight PIPs validated, demonstrated quantitative improvement but concluded the observed performance improvement was not the result of the selected PIP interventions (**Standard 9**).
- All four of the MCPs, for a total of five of the eight PIPs validated, demonstrated statically significant improvement but concluded that the observed improvement was not the result of the selected PIP interventions (**Standard 9**).

An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

Progress on Previous Year (2024) Program Level PIP EQRO Recommendations

Table 11 presents the EQRO recommendations from the previous review alongside the actions implemented by MHD.

Table 11. PIP Program Level Progress on Previous Recommendations.

EQRO Recommendation
The MCPs did not meet all elements for the following validation ratings and overall score. The MCPs will benefit from technical assistance by MHD to ensure the plans meet these requirements. Validation Rating 1 – Overall confidence that the PIP adhered to acceptable methodology for all phases (93%) • Two of the four MCPs, for a total of three PIPs, received a rating of moderate confidence. Validation Rating 2 – Overall confidence that the PIP produced evidence of significant improvement (57.1%) • Two of the four MCPs, for a total of two PIPs validated, received a rating of moderate confidence. • Three of the four MCPs, for a total of four PIPs validated, received a rating of no confidence. Overall score – Aggregate score of the four MCPs' PIP submitted for validation (89.1%) • Two of the four MCPs, for a total of three PIPs validated, received an overall score of partially met. • One of the four MCPs, for a total of one PIP validated, received an overall score of not met.
MHD Response
Following the 2024 EQR results, MHD has revised its Managed Care contract to strengthen PIP expectations. This includes formalizing the use of Required Actions (formerly Corrective Action Plans) to promote accountability and elevate performance across all MCPs. MHD remains engaged with plans to provide technical assistance, support alignment with contract expectations and ensure the successful execution of PIP methodologies.
EQRO Response
The EQRO acknowledges MHD's work in addressing the recommendation. Although the overall PIP performance has improved for the CY2025 PIPS, the majority of PIPs were assigned no (four) and low (three) confidence scores for Validation Rating 2. The recommendation stands.

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Summary of Plan Level PIP Findings

The MCP PIPs were conducted during CY2024 and reviewed in the second half of 2025. Since the review took place after the completion of the PIPs, the findings may not be indicative of current performance.

The following pages provide an overview of each MCP's PIPs, including applicable domains, score, validation status, validation ratings and performance measure results, if applicable.

In addition, the following sections cover key aspects of MCP PIP evaluations, including:

- **Strengths** – Standards scoring at or above 90%
- **Weaknesses/Opportunities for Improvements** – Areas for improvement are identified when an MCP does not meet the scoring element. This language is a synopsis from the PIP Validation Worksheets completed for each PIP
- **Recommendations** – When standard elements receive a finding of “No,” the EQR team documents relevant requirements, provides recommendations and issues an RA. Any RAs issued are focused solely on process changes rather than ongoing performance. These recommendations aim to improve compliance with the protocol and enhance future PIP processes. An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.
- **Areas for Enhancement** – Elements meeting requirements but offering opportunities for further improvement are noted

For more detailed information on the MCPs' PIP results, please refer to the individual [MCP CY2025 EQR PIP validation reports](#).

Healthy Blue

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by HB.

Clinical PIP

PIP Title: Improving Follow-up After Mental Health Hospitalization

PIP Aim Statement: From March to December 2024, HB will collaborate with a major Community Care Behavioral Health Organization (CCBHO) to co-manage members, ages 6 years and older who are post-discharge from a mental health hospitalization and facilitate their entry into the outpatient program, to improve their MY2024 HEDIS® follow-up after hospitalization (FUH) 30-day rate by 2 percentage points from their baseline rate.

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions – Member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - HB partnered with Compass Health, a major CCBHO, to facilitate efficient care transitions. This includes leveraging HB's BH Care Managers (CMs) to act as a bridge between inpatient and outpatient providers. HB's Behavioral Health (BH) CMs

connected with members upon admission to establish rapport, member consent is secured to transfer their care information to Compass Health. Compass Health contacted members within 24 hours of discharge to support post-hospitalization needs, including scheduling a follow-up visit with a BH provider within 30 days.

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - In October 2024, HB identified a 4.1 percentage point decline in the Compass Health second quarter follow-up after hospitalization within 30 days (FUH30) rate. In response, HB initiated a rapid Plan Do Study Act (PDSA) cycle that emphasized re-education for BH staff, enhanced communication and ensured completion of Follow-up after Hospitalization (FUH) assessments through coordinated efforts.
- MCP-focused interventions/system changes – MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices or infrastructure, such as new patient registries or data tools.
 - HB established a dedicated email system between HB CM and CCBHO to facilitate discharge coordination and BH follow-up.

Despite these interventions, HB and Compass Health's FUH30 rate declined from 88.1 percentage points in MY2023 to 85.5 percentage points in MY2024. This is a difference of 2.6 percentage points. HB observed that many referrals to Compass Health were already enrolled in their Health Home. In such cases, HB's CMs transitioned away from direct participation in ongoing care. However, licensed CMs remained available to conduct FUH assessments as needed. HB also noted fewer referrals toward the end of the year. HB believes these two factors may have limited the improvement in FUH30 rates for Compass Health.

Performance Measure Results

Table 12 and Table 13 summarize the performance measures of the Inpatient Re-admissions for Mental Health clinical PIP submitted for validation by HB.

Table 12. HB Clinical Performance Measures and Results: Compass Health's FUH30 Rate.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
Compass Health's FUH30 Rate	345	88.1%	275	85.5%

Results: No Improvement demonstrated; No statistically significant change; p-value 0.327

Table 13. HB Clinical Performance Measures and Results: HEDIS FUH30 Rate.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
HEDIS FUH30 Rate	5122	52.3%	4507	54.9% ▲

Statistically significant increase ▲

Results: Improvement demonstrated; Statistically significant change; p-value < 0.01

Findings

Table 14 provides the findings, along with the applicable standard, for the HB Inpatient Re-admissions for Mental Health clinical PIP.

Table 14. HB Clinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health	
Strengths	
• HB clearly defined and time-specific variables that were appropriate to measure performance and tracked improvement over time (5). • HB completed a risk assessment for the FUH30 PIP and identified several risks that could affect measure performance. Mitigation strategies were implemented to address the identified risks (5). • HB selected performance measures that were appropriate based on data availability and data collection resources (5). • HB identified multiple gaps to the existing performance measures and selected interventions to address the identified gaps (5). • The PIP design outlined a standardized approach for collecting valid and reliable data that accurately represented the identified PIP population (6). • The PIP was designed to clearly specify the data sources needed to support the PIP outcomes (6). • HB described a structured data collection plan that was linked to the analysis plan (6). • HB ensured the data analysis team had relevant qualifications to abstract, analyze and conceptualize the data for the PIP (6). • Data included baseline and repeat measurements. Data was clearly defined and easy to understand (7). • HB provided stakeholders with a clear picture of the changes that occurred during the PIP lifecycle (7). • HB used control groups and randomization to reduce selection bias. Standardized methods ensured consistent data capture. A diverse sampling approach supported comparability over time (7). • HB used data integrity checks to support internal validity (7). • HBs analysis of PIP data highlighted key areas for continuous improvement, allowing HB to implement interventions accordingly (7). • HB utilized data analysis to guide the FUH30 improvement strategy. The strategy was based on evidence from internal data and quality improvement processes (8). • HB included a plan to offer in-person contact for members identified in the PIP (8). • HB improvement strategies were designed to account for or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (8). • HB assessed the success of the improvement strategy using data analysis and interpretation of PIP results (8). • HB aggregate FUH30 rate increased by 2.4 percentage points (9). • Selected interventions significantly contributed to HB's improvement in FUH 30-day rates (9). • HB implemented a sustainability plan following demonstrated improvement in FUH30 rates (9).	
Weaknesses/Opportunities for Improvement	

PIP Title: Inpatient Re-admissions for Mental Health
- The original aim statement includes a goal of a two-percentage-point increase but does not include baseline or goal rates (2). - Compass Health's FUH30 rate declined from 88.1 percentage points in MY2023 to 85.5 percentage points in MY2024 and did not meet the PIP aim statement (9). - Even though the aggregate FUH30 rate demonstrated statistically significant improvement, HB reported the observed improvement was not a result of the chosen intervention (9). - Sustained improvement was not demonstrated for Compass Health, the focus of the PIP (9).
Areas for Enhancement
- HB should revise the aim statement to focus on improving overall HEDIS outcomes (2). - HB should perform a predictive analysis to select performance measures for the PIP (5). - HB should consider using more real-time data to enable faster adjustments and ensure long-term sustainability (8).
Recommendations
HB had one recommendation issued for the clinical PIP. The following standard requires attention and an RA has been issued for HB: Standard 2 – Review the aim statement (85.7%)

Nonclinical PIP

PIP Title: Improving Member Satisfaction

PIP Aim Statement: Between January 1 and December 31, 2024, HB will improve Routine Care (Question 1) on the Post Provider Visit Surveys (PPVS), from 65.66% to 67.66% (two percentage points) by providing real time, customized results and education to targeted providers.

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - HB conducted PPVS, which were designed to mimic CAHPS Survey. Surveys were sent to members, via text message, after each appointment. The PPVS uses five questions that are similar to questions in the CAHPS Survey. This PIP aimed to improve the rate of question one by two percentage points. Since PPVS is claims based, it includes the provider's name in the survey and allows for drill down to the individual providers. In contrast, the CAHPS survey is a blind survey and results are in aggregate form, with separate reports for the Adult, Child General Population and Child with Chronic Conditions Survey. A random selection of providers with a high level of support from the Care Consultant Team were selected as the study group providers. The remaining providers were in the control group, in which individualized results for the PPVS were compiled and monitored but not reviewed with the provider groups. Monthly provider group scorecards and quarterly results were shared with the providers in the study group. HB saw a 2.6 percentage point gain from MY2023 to MY2024. This was likely a result of the selected interventions.

Performance Measure Results

Table 15, Table 16, Table 17 and Table 18 summarize the performance measures of the Inpatient re-admissions for Mental Health nonclinical PIP submitted for validation by HB.

Table 15. HB Nonclinical Performance Measures and Results: Post Provider Visit Survey - Q1. How often did you/your child have an appt as soon as you/they needed a check-up or routine care?

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
Post Provider Visit Survey - Q1. How often did you/your child have an appt as soon as you/they needed a check-up or routine care?	562	65.7%	786	68.3%

Results: Improvement demonstrated; No statistically significant change; p-value 0.303

Table 16. HB Nonclinical Performance Measures and Results: Adult CAHPS-Getting Needed Care.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
Adult CAHPS-Getting Needed Care	127	75.5%	105	81.8%

Results: Improvement demonstrated; No statistically significant change; p-value 0.194

Table 17. HB Nonclinical Performance Measures and Results: Adult CAHPS-Getting Care Quickly.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
Adult CAHPS-Getting Care Quickly	120	78.7%	83*	84.4%

**Denominator less than 100; evaluate with caution*

Results: Improvement demonstrated; No statistically significant change; p-value 0.285

Table 18. HB Nonclinical Performance Measures and Results: Adult CAHPS-Rating of Personal Doctor.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
Adult CAHPS-Rating of Personal Doctor	183	64.5%	148	68.2%

Results: Improvement demonstrated; No statistically significant change; p-value 0.472

Findings

Table 19 provides the findings, along with the applicable standard, for the HB Improving Member Satisfaction nonclinical PIP.

Table 19. HB Nonclinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health	
Strengths	
• HB clearly defined the project population which included members of all ages and exclusion criteria (3). • HB used a two-stage sampling approach to define a complete and accurate list of the target PIP population (4). • HB designed the sample to include a broad range of eligible members who recently received care (4). • HB used a broad sampling method that reflected the population's varied health care experiences and were influenced by factors like age, health status and proximity to care (4). • HB selected performance measures that matched available data and resources. The measures aligned with existing systems and did not require additional resources (5). • HB used interventions that were aligned with accepted clinical guidelines. The measures addressed timely routine care and patient-centered access, which are relevant to HB enrollees (5). • HB clearly specified a systematic method for collecting valid and reliable data (6). • HB linked its data collection plan to its data analysis plan. Data were linked to the PIP goals through member satisfaction metrics. Data was collected electronically and stored securely (6). • The utilization of PPVS has yielded valuable insights into how patients perceive timeliness in care, directly influencing their overall satisfaction (6). • HB identified steps to support comparability between initial and repeat measurements for the PPVS and systematically excluded duplicate responses (7). • HB described multiple strategies to support internal and external validity of the PIP analysis (7). • HB analysis of PIP data highlighted the need to provide providers with more meaningful, actionable feedback (7). • HB used evidence-based strategies to inform the PIP interventions (8). • HB used the PDSA approach to test the improvement strategy. Multiple cycles were evident between March and September 2024 (8). • HB considered confounding variables during implementation of the Member Satisfaction PIP strategy (8). • HB assessed the impact of the improvement strategy and identified areas for continued work (8). • While there were fluctuations in month over month scores, HB monitored results monthly and were able to adjust as needed, thus leading to sustained improvement overtime (9). • Following the observed improvements in the PIP, a sustainability plan has been established to maintain and build on these results (9).	
Weaknesses/Opportunities for Improvement	
• While the progress in Routine Care is encouraging, there is no statistical evidence that the intervention has shown significant improvement (9).	
Areas for Enhancement	
• Although the aim statement meets all elements of the standards, HB should consider revising the aim statement to focus on improving CAHPS outcomes, while utilizing the PPVS as an intervention to align the aim statement with contractual obligations (2).	

PIP Title: Inpatient Re-admissions for Mental Health
HB should perform a predictive analysis to select performance measures for the PIP (5).
Recommendations
HB did not receive any recommendations for the nonclinical PIP.

Home State Health

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by HSH.

Clinical PIP

PIP Title: Follow Up After Mental Health Discharge (FUH)

PIP Aim Statement: From January 1, 2024, to December 31, 2024, HSH will increase the Healthcare Effectiveness Data and Information Set (HEDIS®) rate "Follow Up After Mental Health Discharge within 30 Days" (FUH 30-day) by two percentage points 50.58% in 2023 to 52.58% in 2024 for HSH General Plan (GP).

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - HSH developed a multi-question quantitative survey and distributed it to providers via virtual meetings to assess understanding of follow-up care. After initially low response rates, HSH revised the survey and delivery system. The revised survey included demographic questions to try and increase feedback. HSH also changed the delivery method from virtual meetings to email to increase engagement. However, response rates declined with only 42 of approximately 12,000 providers responding. Going forward, HSH will include future surveys as part of provider Lunch and Learn presentations to increase provider response rates.
 - HSH used the 42 provider surveys to conduct a data analysis that identified potential barriers providers may face when coordinating follow-up care. One barrier identified was providers' understanding of the FUH30 HEDIS measure. Survey responses were then used to design an initial provider education effort focused on the FUH30 measure and state-specific resources. HSH was also able to publish an FUH one pager and BH HEDIS Toolkit on the HSH website.

Although the overall FUH30 rate increased in measurement year 2025 (MY2024), HSH determined the improvement was not likely the result of PIP interventions. Future potential follow-up activities include monitoring engagement with the FUH one pager and HEDIS BH Toolkit on HSH website.

Performance Measure and Results

Table 20 summarizes the performance measures of the Inpatient re-admissions for Mental Health clinical PIP submitted for validation by HSH.

Table 20. HSH Clinical Performance Measures and Results: HSH HEDIS FUH30 Rate.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
HEDIS FUH30 Rate	4,146	50.6%	3,543	54.1% ▲

Statistically significant increase ▲

Results: Improvement demonstrated; Statistically significant change; p-value <0.01

Findings

Table 21 provides the findings, along with the applicable standard, for the HSH Inpatient re-admissions for Mental Health clinical PIP.

Table 21. HSH Clinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
• HSH conducted a thorough risk assessment and identified appropriate mitigation strategies to minimize the identified risks (5). • HSH selected performance measures that assess an important aspect of care. Readmission rates were used to evaluate whether timely follow-up contributed to reduced hospitalizations (5). • For both PDSAs, HSH used provider surveys to gather data on provider understanding and barriers to care. Survey results were compared to FUH30 and readmission data to explore potential correlations (5). • FUH30 rates were tracked before and after interventions to evaluate their effectiveness (5). • Criteria for inclusion and exclusion were clearly defined. HSH acknowledged limitations in race and ethnicity data but addressed this using internal reporting (5). • HSH clearly specified a systematic method for collecting valid and reliable data that represented the population in the PIP (6). • HSH clearly specified multiple data sources used throughout the PIP design (6). • The qualitative data collection methods were well-defined and structured to gather meaningful insights from key providers (6). • HSH conducted the analysis in accordance with the data analysis plan (7). • HSH consistently used the same metrics for both baseline and repeat measurements across all key outcomes, including FUH30 rates, readmission rates and surveys (7). • The PIP clearly demonstrated a comprehensive comparison of results across multiple entities (7). • HSH identified several challenges with some interventions. HSH acknowledged the limitations of their initial approaches and adapted to future plans accordingly (7). • HSH effectively identified possible follow-up activities (8).
Weaknesses/Opportunities for Improvement
• The analysis did not fully address factors affecting internal validity. Technical issues delayed data analysis and limited trend assessment. Selecting metrics based on availability rather than FUH30 denominators reduced sample representativeness and weakened the validity of findings (7).

PIP Title: Inpatient Re-admissions for Mental Health

- HSH implementation strategy did not account for major confounding variables that could impact PIP outcomes during PDSA 1 such as low survey return rates **(8)**.
- Even though HSH overall FUH30 rate increased in MY2024, HSH determined the improvement was not likely the result of planned interventions **(9)**.
- Although HSH demonstrated statistically significant improvement, HSH determined the statistically significant improvement was not likely the result of the interventions **(9)**.

Areas for Enhancement

- Even though the control group is listed in the aim statement description, it is not correctly defined. HSH should ensure that the experimental and control groups are aligned with the aim statement. **(2)**.
- While the aim statement addresses the study timeframe, the response does not specify the length of enrollment for the study population. HSH should define length of enrollment for the study population **(3)**.
- When defining the population of the PIP, HSH should ensure that the experimental and control groups align with the aim statement **(3)**.
- HSH should consider standardizing all survey cycles to allow for more meaningful comparisons over time **(5)**.
- HSH should consider conducting a problem map analysis when selecting the performance measures **(5)**.
- HSH should perform a predictive analysis to select performance measures for the PIP **(5)**.
- HSH should enhance how some data elements are defined **(6)**.
- HSH should consider developing a comprehensive data collection process **(6)**.
- HSH should consider scaling system-level changes earlier in the PIP timeline, integrating ongoing monitoring mechanisms and ensuring that interventions are measurable **(8)**.
- HSH should restructure future PDSAs to ensure experimental and control groups are well-defined and comparable **(8)**.
- HSH should implement rapid PDSA cycles for all PIP interventions **(8)**.
- HSH should develop a detailed statewide expansion plan. If interventions do not render improvement over time, HSH should clearly document why a statewide expansion plan was not feasible **(8)**.
- HSH should consider incorporating interventions that include in-person contact for clinical PIPs **(8)**.
- HSH should complete a root cause analysis to identify the cause of the improvement and implement strategies to maintain the improvement **(9)**.

Recommendations

HSH had two recommendations issued for the clinical PIP. The following standards require attention and RAs have been issued for HSH:

- Standard 7 – Review data analysis and interpretation of PIP results (87.5%)
- Standard 8 – Assess the improvement strategies (80.0%)

Nonclinical PIP

PIP Title: Member Satisfaction

PIP Aim Statement: From January 1, 2024, to December 31, 2024, HSH will implement interventions to improve Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for GP from baseline to measurement:

- Getting Needed Care by 3 percentage points from 85.47% in 2024 to 88.47% in 2025
- Rating of Health Care by 2 percentage points from 70.1% to 72.1% in 2025.

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions – Member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - HSH created a multi-question survey delivered via text message to gather information on member-reported barriers to care and understanding of benefits. The survey was ready in May 2024. The first survey was distributed that same month to members who enrolled between January and February 2024, with analysis completed in June 2024. The second survey was sent in July to members who enrolled between March and April 2024, with analysis completed in August 2024.
 - Survey responses were used to develop an educational targeted member text message campaign, which was developed in September 2024. The campaign addressed the specific barriers and benefits identified by members. In October 2024, all members included in the January-April surveys received the education. HSH was unable to determine if the education campaign was successful. Exploratory work groups were held on how to best move forward with future PIPs. HSH recognized limitations in data granularity and the minimal effect of the text campaign on My Health Pays utilization. They applied these lessons to propose future improvements, including developing a repository for benefit communications and modifying survey length and delivery methods.

Performance Measure Results

Table 22 and Table 23 summarize the performance measures of the Inpatient re-admissions for Mental Health nonclinical PIP submitted for validation by HSH.

Table 22. HSH Nonclinical Performance Measures and Results: Getting Needed Care.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS Survey, Composite Score: Getting Needed Care	NA	85.5%	NA	89.8% ▲

Statistically significant increase ▲

Results: Improvement demonstrated; Statistically significant change; p-value 0.05

Table 23. HSH Nonclinical Performance Measures and Results: Rating of Health Care.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS: Rating of Health Care	241	70.1%	150	68.0%

Results: No improvement demonstrated; No statistically significant change; p-value 0.65

Findings

Table 24 provides the findings, along with the applicable standard, for the HSH Improving Member Satisfaction nonclinical PIP.

Table 24. HSH Nonclinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
• HSH clearly defined the project population in alignment with the study question (3). • HSH used a sample frame that aligned with NCQA technical requirements. For PDSA cycles, HSH used stratified sampling based on recent enrollments that were appropriate and based on a complete and current list of eligible members (4). • HSH utilized an external vendor to complete its statistical analysis for the PIP interventions and adjusted the targeted response rate to the vendors minimum requirements (4). • HSH effectively selected performance measures related to member understanding of benefits and access to care (5). • HSH utilized available survey and administrative data to assess member satisfaction, benefit understanding and service utilization. The measures were appropriate given the anonymous nature of CAHPS and HSH's access to internal data sources (5). • HSH used CAHPS survey data to monitor performance at any point in time and compared results against national benchmarks (5). • HSH proactively used interventions to understand and improve member satisfaction with access to care (5). • HSH identified a systematic method for collecting valid and reliable data for the PIP (6). • HSH clearly specified data sources for each measure (6). • HSH effectively linked its data collection plan to the data analysis plan. The data collected was sufficient to conduct significance testing and assess intervention impact (6). • HSH used consistent data collection instruments over the time period studied (6). • HSH used the same metrics for baseline and remeasurements across CAHPS and PDSA variables, which supported comparability. Whenever possible, HSH conducted significance testing for some individual items (7). • HSH addressed the validity of the analysis findings (7). • HSH effectively identified lessons learned and used the findings to propose future improvements (7).

PIP Title: Inpatient Re-admissions for Mental Health
- HSH effectively used the EQRO CY2023 PIP feedback and survey analysis to inform its selection of overall improvement strategies (8). - HSH designed its member engagement strategy based on data collected through a structured quality improvement process (8).
Weaknesses/Opportunities for Improvement
- HSH did not provide materials in the members' language of their choice (8). - Per HSH response, the MCP did not account for any major confounding variables during the implementation of either PDSA cycle (8). - HSH reported that the goal outlined in the aim statement was not achieved (9). - Although there was demonstrated improvement in performance for Getting Needed Care, HSH determined the statistically significant improvement was not likely the result of the interventions (9). - Even though HSH demonstrated statistically significant improvement in Getting Needed Care, HSH determined the statistically significant improvement was not likely the result of the interventions (9).
Areas for Enhancement
- HSH should consider conducting a problem map analysis when selecting the performance measures (5). - HSH should perform a predictive analysis to select performance measures for the PIP (5). - HSH should include exclusion criteria in the data analysis plan, such as specifying that significance testing will not be conducted on performance measures with fewer than 100 data points (7). - HSH should implement rapid PDSA cycles for all PIP interventions (8). - HSH should consider reviewing CAHPS data in September, prior to the start of the upcoming measurement year. Interventions should be developed from October through December to allow for implementation in Q1 of the measurement year (8).
Recommendations
HSH had two recommendations issued for the nonclinical PIP. The following standards require attention and RAs have been issued for HSH: Standard 8 – Assess the improvement strategies (75.0%)

Show Me Healthy Kids

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by SMHK.

Clinical PIP

PIP Title: Follow Up After Mental Health Discharge (FUH)

PIP Aim Statement: From January 1, 2024, to December 31, 2024, SMHK will increase the Healthcare Effectiveness Data and Information Set (HEDIS®) rate "Follow Up After Mental Health Discharge within 30 Days" (FUH30) by two percentage points 74.32% in 2023 to 76.32% in 2024 for SMHK.

Domain(s): Timeliness and Access

Validation Status: Yes**Improvement Strategies/Interventions**

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - SMHK developed a multi-question quantitative survey and distributed it to providers via virtual meetings to assess understanding of follow-up care. After initial low response rates, SMHK revised the survey and delivery system. The revised survey included demographic questions to try and increase feedback. SMHK also changed the delivery method from virtual meetings to email to increase engagement. However, response rates declined with only 42 of approximately 12,500 providers responding. Going forward, SMHK will include future surveys as part of provider Lunch and Learn presentations.
 - SMHK used the 42 provider surveys to conduct a data analysis that identified potential barriers providers may face when coordinating follow-up care. One barrier identified was providers understanding of the FUH30 HEDIS measure. Survey responses were then used to design an initial provider education effort focused on the FUH30 measure and state-specific resources. SMHK was also able to publish an FUH one pager and BH HEDIS Toolkit on the SMHK website.
 - SMHK utilized a Foster Care Center of Excellence model and encouraged Jordan Valley to provide multiple services during one visit. Jordan Valley Community Health Center offers care across nine locations, mobile services and two school-based clinics. With these services they have a variety of options and ways to serve nearly 10% of the SMHK population. In December 2023, Jordan Valley went live with a dedicated phone and navigator. The SMHK care management (CM) teams continue to meet regularly with Jordan Valley's clinical and executive leadership to discuss implementation challenges and identify possible solutions.

Although the overall FUH30 rate increased in MY2024, SMHK determined the improvement was not likely the result of PIP interventions. Future potential follow-up activities include monitoring engagement with the FUH one pager and HEDIS BH Toolkit on SMHK website.

Performance Measure Results

Table 25 summarizes the performance measures of the Inpatient re-admissions for Mental Health clinical PIP submitted for validation by SMHK.

Table 25. SMHK Clinical Performance Measures and Results: HEDIS FUH30 Rate.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
HEDIS FUH30 Rate	2,667	74.3%	2,505	78.9% ▲

Statistically significant increase ▲

Results: Improvement demonstrated; Statistically significant change; p-value <0.01

Findings

Table 26 provides the findings, along with the applicable standard, for the SMHK Inpatient re-admissions for Mental Health clinical PIP.

Table 26. SMHK Clinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health	
Strengths	
• SMHK correctly utilized both outcome and process measure populations when identifying the experimental and control groups (3). • SMHK conducted a thorough risk assessment by identifying key risks and specifying corresponding mitigation strategies (5). • SMHK selected measures that reflected important aspects of care that directly impact enrollees' health and functional status (5). • SMHK selected performance measures that were appropriate based on the availability of data and resources (5). • SMHK used FUH rates to monitor performance at a point in time and track changes over time. Performance was discussed during regular cross-departmental meetings (5). • SMHK acknowledged limitations in race and ethnicity data but addressed this using internal reporting (5). • SMHK specified a systematic method for collecting valid and reliable data. Data represented the PIP population and was stratified by demographics and provider region (6). • The PIP design clearly specified data sources. Each data source was identified by type and linked to a specific measure or PDSA activity (6). • The PIP design clearly defined the data elements to be collected. The clearly defined elements supported consistent and accurate measurement across the PIP (6). • SMHK used consistent metrics across baseline and repeat measurements for FUH30 and other outcomes (7). • SMHK identified multiple lessons learned related to less-than-optimal performance throughout all three PDSA cycles. SMHK plans to conduct a root cause analysis in 2025 to demonstrate a continuous improvement approach (7). • SMHK designed interventions based on identified root causes from data analysis and quality improvement processes (8).	
Weaknesses/Opportunities for Improvement	
• SMHK did not consistently account for major confounding variables that may have affected the PIP outcomes (8). • Though SMHK's overall FUH30 rate rose in MY2024, SMHK determined the improvement was not likely the result of planned interventions (9). • Even though SMHK demonstrated statistically significant improvement in MY2024, SMHK determined the statistically significant improvement was not likely the result of the interventions (9).	
Areas for Enhancement	

PIP Title: Inpatient Re-admissions for Mental Health

- SMHK should clearly define the PIP population criteria, such as required enrollment duration, study timeframes and exclusion criteria **(3)**.
- SMHK should consider standardizing all survey cycles to allow for more meaningful comparisons over time **(5)**.
- SMHK should consider conducting a problem map analysis when selecting the performance measures **(5)**.
- SMHK should perform a predictive analysis to select performance measures for the PIP **(5)**.
- Whenever possible, automate aspects of the data collection process **(6)**.
- SMHK should define selection criteria that align with analytic goals and ensure sufficient denominator sizes **(7)**.
- SMHK should consider shortening PDSA cycle intervals and ensuring more frequent data monitoring and adaptation to align with rapid cycle improvement principles **(8)**.
- SMHK should develop a detailed statewide expansion plan. If interventions do not render improvement over time, SMHK should clearly document why a statewide expansion plan was not feasible **(8)**.
- SMHK should consider incorporating interventions that include in-person contact for clinical PIPs. In-person contact interventions may assist in increasing FUH30 rates **(8)**.
- SMHK should complete a root cause analysis to identify the cause of the improvement and implement strategies to maintain the improvement **(9)**.

Recommendations

SMHK had one recommendation issued for the clinical PIP. The following standard requires attention, and an RA has been issued for SMHK:

- Standard 8 – Assess the improvement strategies (80.0%)

Nonclinical PIP**PIP Title:** Member Satisfaction

PIP Aim Statement: From January 1, 2024, to December 31, 2024, SMHK will implement interventions to improve Child CAHPS survey results for SMHK from baseline to measurement:

Getting Needed Care by 3 percentage points from 85.8% to 88.8%

Rating of Health Care by 2 percentage points from 72.1% to 74.1%

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - For PDSA 1, SMHK planned a collaborative intervention involving SMHK CM and selected Division of Youth Services (DYS) facilities. Planned activities included providing education to DYS team members on quality and access to care, as well as improving access to routine care through dental mobile services. However, the educational intervention was abandoned due to limited DYS capacity to participate in project

development. The dental mobile service component was also abandoned after DYS reported that the selected facilities no longer required mobile dental support and were better positioned to provide dental care than they had been two years prior. As a result, PDSA 1 was abandoned in June 2024 without implementation, and no data was collected.

- MCP-focused interventions/system changes – MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices or infrastructure, such as new patient registries or data tools.
 - SMHK implemented a transportation workgroup to strengthen the relationship with its transportation vendor Medicaid Transportation Missouri. The group identified that partnership was critical to improving access to care. Additionally, SMHK introduced escalation emails to support timely resolution of complex transportation requests. CM used email to communicate directly with Medicaid Transportation Missouri, allowing for easier resolution of issues such as visit coordination and reimbursement processing. While there were isolated cases requiring follow-up, the intervention provided a more streamlined process for handling transportation needs and reflects a system-level change focused on improving access and care coordination. Although the intervention was not determined to have an impact on the overall Consumer Assessment of Healthcare Providers and Systems (CAHPS scores, SMHK plans on continuing efforts into 2025.

Performance Measure Results

Table 27 and Table 28 summarize the performance measures of the Improving Member Satisfaction nonclinical PIP submitted for validation by SMHK.

Table 27. SMHK Nonclinical Performance Measures and Results: Getting Needed Care.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS Survey, Composite Score: Getting Needed Care	NA	85.8%	NA	92.3%

Results: Improvement demonstrated; No statistically significant change; p-value 0.27

Table 28. SMHK Nonclinical Performance Measures and Results: Rating of Health Care.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS: Rating of Health Care	122	72.1%	279	76.3%

Results: Improvement demonstrated; No statistically significant change; p-value NA

Findings

Table 29 provides the findings, along with the applicable standard, for the SMHK Inpatient re-admissions for Mental Health nonclinical PIP.

Table 29. SMHK Nonclinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health	
Strengths	
• SMHK clearly defined the project population (3). • SMHK conducted a risk assessment that identified potential risks and included appropriate mitigation strategies to address them (5). • SMHK selected performance measures that were appropriate based on the availability of data and resources. SMHK measures aligned with the available data sources. These data sources were appropriate to assess the impact of the intervention on member satisfaction and access (5). • SMHK effectively used proxy measures that addressed areas important to enrollees. The data sources used allowed SMHK to calculate the measures consistently (5). • SMHK used consistent data collection instruments for PDSA 2 (6). • SMHK evaluated the effectiveness of PDSA 2 and outlined concrete next steps to strengthen future analysis (7). • SMHK effectively conducted analysis through workgroups to identify operational barriers in the performance improvement process. In response to identified barriers, SMHK implemented processes to improve clarity and coordination for complex requests (8).	
Weaknesses/Opportunities for Improvement	
• SMHK did not use a sampling frame for its PDSA cycles. As a result, it is not possible to assess whether a complete, recent and accurate list of the target PIP population was established (4). • SMHK did not use sampling methods for its PDSAs. SMHK was unable to ensure that the target population was sufficient to produce reliable and valid results (4). • Sampling methods were not used for PDSA 1 and PDSA 2. SMHK did not provide a description of valid sampling techniques or other safeguards to demonstrate how bias was minimized (4). • SMHK analysis did not account for factors that may threaten the internal or external validity of the findings (7). • SMHK design strategy did not account for or adjust for any major confounding variables that could have had an obvious impact on PIP outcomes (8). • SMHK determined the performance improvement was not likely the result of planned interventions (9). • There is no statistical evidence that the intervention has shown significant improvement (9).	
Areas for Enhancement	
• SMHK should consider including a control group for all PDSAs to strengthen the internal validity of future interventions (2). • SMHK should identify the control group at the same time the PIP population is selected for each PDSA (3). • SMHK should conduct a five-why's, root cause analysis or key driver diagram analysis to identify appropriate performance measures for future PDSAs (5). • SMHK should perform a predictive analysis to select performance measures for the PIP (5). • SMHK should develop standardized protocols for collecting and validating data used in PDSA cycles. SMHK should confirm that internal data sources are consistently documented and verifiable to support reliable analysis (6).	

PIP Title: Inpatient Re-admissions for Mental Health
• SMHK should consider documenting procedures in more detail to ensure reproducibility. This will help maintain consistency and accuracy in future cycles (6). • SMHK should consider implementing rapid PDSA cycles for future work (8). • SMHK should create a detailed statewide expansion plan. If interventions do not render improvement over time, SMHK should clearly document why a statewide expansion plan was not feasible (8).
Recommendations
SMHK had five recommendations issued for the nonclinical PIP. The following standards require attention and RAs have been issued for SMHK: • Standard 4 – Review the sampling method (25.0%) • Standard 7 – Review data analysis and interpretation of PIP results (87.5%) • Standard 8 – Assess the improvement strategies (80.0%)

UnitedHealthcare

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by UHC.

Clinical PIP

PIP Title: Mental Health Follow-up After Hospitalization (FUH30)

PIP Aim Statement: Improve overall rates of Healthcare Effectiveness Data and Information Set (HEDIS®) FUH30 day by two percentage points from 45.45% to 47.45% from January 2024 through December 2024, in Temporary Assistance for Needy Families (TANF) and Expansion product ages 6 to 65 in the state of Missouri, by enhancing care coordination and member communication.

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions – Member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - In August 2024, UHC implemented email outreach to members with a BH inpatient admission. Messages included information on recovery planning, follow-up visit expectations, provider search and appointment assistance, care management enrollment, transportation support and how to earn an incentive.
- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - In 2023, UHC created a collaboration email box for Sisters of St. Mary St. Joseph Hospital partners to initiate care coordination upon member admission. The BH team monitored this inbox for new admissions and used it to conduct proactive outreach and initiate collaboration. In February 2024, the intervention was adapted to include provider verification activity tracking to address claims lag. This activity continued

through June 2024 but was abandoned after no improvement was observed in FUH30 compliance compared to Sisters of St. Mary DePaul Hospital. No other provider interventions were implemented during 2024.

Performance Measure Results

Table 30 summarizes the performance measures of the Inpatient Re-admissions for Mental Health clinical PIP submitted for validation by UHC.

Table 30. UHC Clinical Performance Measures and Results.

Performance Measure	MY2023 Baseline Sample Size	MY2023 Baseline Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
HEDIS FUH30 Rate	3,908	45.5%	3,330	49.5% ▲

Statistically significant increase ▲

Results: Improvement demonstrated; Statistically significant change; p-value <0.05

Findings

Table 31 provides the findings, along with the applicable standard, for the UHC Inpatient re-admissions for Mental Health clinical PIP.

Table 31. UHC Clinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
- UHC clearly specified the improvement strategy, population, control group and the time period for the PIP in the aim statement (2). - UHC clearly defined the project population for the FUH30 PIP (3). - UHC clearly defined the control groups for both populations. This approach helped ensure the validity and reliability of the study results, enhanced reproducibility and reduced potential bias in the PIP (3). - UHC effectively utilized quality improvement tools such as a driver diagram to identify primary and secondary drivers and appropriate interventions for the PIP (5). - UHC effectively completed a risk assessment for the PIP and designed appropriate mitigation strategies to address identified vulnerabilities, ensure project continuity and minimize potential disruptions to performance and outcomes (5). - UHC used multiple data sources to track performance measures related to FUH30. These measures aligned with the intervention goals and used appropriate data sources to evaluate outcomes (5). - UHC designed interventions based on clinicians and schedulers experience and the needs of the organization (5). - UHC identified a gap in the timeliness of HEDIS FUH30 data due to claims lag. To address this, UHC developed a new measure to assist with activity tracking. This ensured reliable and accurate evaluation of FUH30 compliance while addressing a limitation in existing data sources (5). - UHC identified gaps in the data automation process and the data needed for the assessment of the performance measures that could not be automatically tracked. UHC ensured that staff collecting

PIP Title: Inpatient Re-admissions for Mental Health
the data received multiple trainings on correct data collection processes to maintain data validity (6). • UHC presented the PIP findings in a concise and easily understood manner (7). • UHC identified lessons learned related to less-than-optimal performance. These reflections supported continuous improvement and informed adjustments to intervention strategies (7). • UHC designed interventions based on identified barriers. The interventions were measurable and monitored monthly (8). • Although UHC did not implement rapid PDSA cycles, longer PDSA cycles were implemented for the PIP. This was due to the lag in claims processing (8).
Weaknesses/Opportunities for Improvement
• Though UHC's overall FUH30 rate rose in MY2024, UHC determined the improvement was not likely the result of planned interventions (9). • Even though UHC demonstrated statistically significant improvement in MY2024 for FUH30, UHC determined the statistically significant improvement was not likely the result of the interventions (9).
Areas for Enhancement
• UHC should perform a predictive analysis to select performance measures for the PIP (5). • Whenever possible, UHC should utilize automation for data collection (6). • Consider using a t-test when comparing two variables such as two hospitals. Chi-squared tests can be utilized when comparing three or more hospitals in a plan (7). • When displaying data in a bar graph, UHC should ensure the y axis starts with 0% and ends with 100% (7). • UHC should consider strengthening future strategies by incorporating provider engagement or policy change components (8). • UHC should consider ways to reduce claims lag or use more real-time data sources to enable shorter PDSA cycles and faster adaptation (8). • UHC should consider implementing small tests of change before rolling out the intervention system-wide (8). • UHC should consider how in-person contact could enhance the interventions and outcomes of FUH30 (8). • UHC should complete a root cause analysis to identify the cause of the improvement and implement strategies to maintain the improvement (9).
Recommendations
• UHC did not receive any recommendations for the clinical PIP.

Nonclinical PIP

PIP Title: Member Satisfaction: Improve CAHPS Scores

PIP Aim Statement: Improve member satisfaction scores for the parents or guardians of qualified CHIP members (< 17 years of age during the measurement year 2024) for two defined Consumer Assessment of Health Plan Systems survey measures by at least five percentage points or sustain > 75th national

percentile by the end of MY2024 (reported out in August 2025), by enhancing customer service agents' ability to address member needs. The two focus areas are: Improve customer service - Provided information or help: improve from 79.7% to 82.2% and Rating of health care: improve from 69.4% to 71.9%.

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions – Provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education and outreach.
 - During customer service calls, UHC members were asked, "Have I given you the information or help you need today?" Members were also asked to confirm that their concerns were fully addressed and that they felt more in control of their health care.
- MCP-focused interventions/system changes – MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices or infrastructure, such as new patient registries or data tools.
 - UHC customer service advocates were trained to use a standard closing question on calls: "Have I given you the information or help you need today?" This approach was used to assess member satisfaction and gather real-time feedback to inform service improvements.
 - UHC implemented the Net Promoter Score and User Experience Surveys in MY2023 and continued the use of the surveys in MY2024. These tools were used to assess whether member satisfaction improved following targeted coaching interventions.
 - Recognizing that Net Promoter Score and User Experience Surveys results do not always align with Consumer Assessment of Healthcare Providers and Systems (CAHPS) result, UHC introduced the CARE training program in July 2024 to support advocate development and enhance member interactions. The CARE training was implemented for all existing and new hire advocates and focused on career growth, allyship, engagement, resilience and problem-solving. The training aims to promote a positive and supportive work environment and is designed to improve the quality of member service, contributing to improved satisfaction outcomes.

Performance Measure Results

Table 32 and Table 33 summarizes the performance measures of the Inpatient re-admissions for Mental Health nonclinical PIP submitted for validation by UHC.

Table 32. UHC Nonclinical Performance Measures and Results: Provided Information or Help.

Performance Measure	MY2022 Baseline Sample Size	MY2022 Baseline Rate	MY2023 First Remeasurement Sample Size	MY2023 First Remeasurement Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA CAHPS Survey, Provided information or help	64	79.7%	74	79.7%	41	78.1%

Results: No Improvement demonstrated; No statistically significant change; p-value 1.0

Table 33. UHC Nonclinical Performance Measures and Results: Rating of Health Care.

Performance Measure	MY2022 Baseline Sample Size	MY2022 Baseline Rate	MY2023 First Remeasurement Sample Size	MY2023 First Remeasurement Rate	MY2024 Most Recent Sample Size	MY2024 Most Recent Rate
NCQA CAHPS Survey, Rating of Health Care	278	69.4%	208	70.7%	164	70.1%

Results: No improvement demonstrated; No statistically significant change; p-value 0.90

Findings

Table 34 provides the findings, along with the applicable standard, for the UHC Improving Member Satisfaction nonclinical PIP.

Table 34. UHC Nonclinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
- UHC used a systematic sampling method to select parents or guardians of qualified members. Systematic sampling involves selecting members at regular intervals from an ordered list after a random start. Additionally, systematic sampling was efficient and practical for working with a large, structured population. This sampling method supported the representativeness and reliability of the PIP population (4). - UHC selected objective and clearly defined variables to measure performance and improvement (5). - UHC identified a key risk related to inconsistent advocate performance and linked it to past member dissatisfaction (5). - UHC effectively used monthly call audits and member satisfaction surveys to monitor performance at a point in time. The results informed quality improvement activities by identifying areas of strength and opportunities for improvement (5). - Selected performance measures allowed for frequent tracking of member experience. UHC confirmed that the interventions were not based on clinical guidelines, but it had consulted MHD during development of the intervention. This demonstrated UHC's effort to align the PIP strategy with expert clinical knowledge in the absence of applicable clinical practice guidelines (5). - UHC clearly specified a systematic method for collecting valid and reliable data (6). - UHC identified a gap between CAHPS and internal survey results and developed alternate interventions to improve member satisfaction (7). - UHC described interventions that addressed identified barriers and aimed to influence member experience. Ongoing work groups discussed root causes and best practices to address barriers, when necessary (8).

PIP Title: Inpatient Re-admissions for Mental Health
- UHC identified a timing limitation with CAHPS survey data and addressed it by using the member satisfaction survey to evaluate interventions monthly. This adjustment helped support timely monitoring (8). - UHC assessed strategy success using CAHPS and internal survey results, noted minimal changes in performance and identified follow-up activities (8).
Weaknesses/Opportunities for Improvement
- UHC did not describe how the analysis accounted for factors that may threaten internal or external validity (7). - UHC reported that the goal outlined in the aim statement was not achieved (9). - UHC noted that the observed improvement in the performance measures was not likely due to the selected PIP intervention (9). - There is no statistical evidence that the intervention has shown significant improvement (9).
Areas for Enhancement
- UHC should consider identifying or describing a control group to support comparison and attribution of changes to the intervention (2). - UHC should consider using stratified or staged implementation of interventions with internal non-anonymous survey tools to evaluate intervention impact in future PIPs (3). - UHC should perform a predictive analysis to select performance measures for the PIP (5). - UHC should specify separate risks or mitigation strategies for each selected performance measure. Future risk assessments should address each performance measure individually to strengthen alignment between risks and performance outcomes (5). - When designing a data collection plan, UHC should consider automation whenever possible (6). - UHC should consider using a t-test when comparing two variables such as years. Chi-squared tests can be utilized when comparing three or more variables (7). - When displaying data in a bar graph, UHC should ensure the y axis starts with 0% and ends with 100% (7). - When comparing results across multiple entities, UHC should consider including its own data, in a different color, on the bar graphs (7). - Even though the PIP results and findings were presented in a concise and easily understood manner, UHC should use best practices when displaying data in graphs (7). - UHC should consider implementing rapid PDSA cycles for future work (8). - UHC should consider implementing small tests of change before rolling out the intervention system-wide (8).
Recommendations
UHC had one recommendation issued for the nonclinical PIP. The following standard requires attention and an RA has been issued for UHC: Standard 7 – Review data analysis and interpretation of PIP results (87.5%)

Progress on Previous Year (2024) Plan Level PIP EQRO Recommendations

Table 35 presents the plan level EQRO recommendations from the previous review, along with the degree to which plans have addressed the previous year's EQRO recommendations. The MCPs' efforts to address these recommendations were assessed through the RA process during the current review

period and are summarized below. MCP-specific progress is provided in the individual [MCP 2025 PIP validation reports](#).

Key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Table 35. PIP Plan Level Progress on Previous Recommendations.

MCP	Total Rcv'd	Met	Not Met	Degree to which plans addressed all EQRO recommendation(s)
HB	0	0	0	NA
HSH	15	12	3	Medium
SMHK	1	1	0	High
UHC	9	9	0	High

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Performance Measure Validation (PMV)

Objective

PMV is a required EQR activity described at §438.358(b)(1)(ii) which mandates that the state or an EQRO must validate the performance measures that were calculated during the preceding 12 months. Per §438.330(c), states specify standard performance measures which the MCPs must include in their QAPI program. These measures are used to monitor the performance of the individual MCPs at a point in time, to track performance over time, to compare performance among MCPs and to inform the selection and evaluation of quality improvement activities.

Overview



PMV is conducted according to federal protocol standards, *CMS Protocol 2. Validation of Performance Measures*. The review assesses the accuracy of performance measures reported by the MCP and determines the extent to which performance measures calculated by the MCP follow state specifications and reporting requirements.

Assessment of an MCP's information system is required as part of performance measures validation and other mandatory review activities. To meet this requirement, information gathered during the HEDIS audit was reviewed by Comagine Health. See [Appendix B: PMV Methodology](#) for more information.

NCQA HEDIS® measures are standardized performance measures developed by NCQA and used to objectively measure, report and compare quality across health plans. Percentiles are used to represent the relative performance of health plans compared to other health plans and help assess how well a plan performs on various quality measures.

The performance measures for MY2022–MY2024, reported in CY2025, are outlined in the *Quality Improvement Strategy – 2024 State of Missouri MO HealthNet Division*. The following 15 measures related to promoting wellness and prevention, were derived from Goal 2 and select measures from the *Quality Metrics and Performance Targets of the QIS*:

- **Objective: Promote Child Health**
 - Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)
 - Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)
 - Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV)
 - Oral Evaluation, Dental Services (0-20 Years) (Total) (OED)
 - Childhood Immunization Status (Combo 10) (CIS)
 - Immunizations for Adolescents (13 Years) (Combo 2) (IMA)⁹
 - Lead Screening in Children (LSC)
- **Objective: Promote Chronic Disease Management**
 - Asthma Medication Ratio (Total) (AMR)
 - Glycemic Status Assessment for Patients with Diabetes (GSD). HbA1c Control <8%

⁹ MHD's quality improvement strategy for MY2022 and MY2023 included Immunizations for Adolescents (Combo 1) (IMA) but was intended to include Immunizations for Adolescents (Combo 2) (IMA). This report has been updated to align with the state's quality improvement strategy and includes Combo 2 rather than Combo 1.

- Controlling High Blood Pressure (CBP)
- **Objective: Promote Women’s Health**
 - Timeliness of Prenatal Care (PPC)
 - Postpartum Care (PPC)
 - Chlamydia Screening in Women (Total) (CHL)
- **Objective: Improve Management of Behavioral Health (BH) and Substance Use Disorder (SUD)**
 - Follow-Up After Hospitalization for Mental Illness (30 Days) (Total) (FUH)
 - Follow-Up after Emergency Department Visit for Mental Illness (30 Days) (Total) (FUM)

Methodology

The performance measures identified by MHD are NCQA HEDIS measures, which are validated by a certified NCQA HEDIS auditor. The HEDIS audit included a review of the MCPs’ overall information systems (IS) capabilities for collecting, storing, analyzing and reporting health information. The MCPs’ must:

- Process medical, member and provider information as a foundation for accurate HEDIS reporting.
- Demonstrate effective systems, information practices and control procedures for producing and using information in core business functions.

The review of IS was performed to collect information that documents the MCPs’ efforts to ensure the accuracy and completeness of reported HEDIS rates. The findings from the IS review formed the basis of a closer examination of the procedures used to develop the various HEDIS measures. The standards by which the MCPs’ IS systems were judged are defined by NCQA.

Comagine Health did not validate the measures but performed an analysis of the reported results as presented in the FARs of the MCP HEDIS Compliance Audits. See the [Information System Capabilities Assessment \(ISCA\)](#) section for additional information on the HEDIS audit and FARs.

Scoring

Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles:

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 50th and 75th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

For a full description of the methodology, including technical methods of data collection, description of data obtained and how Comagine Health aggregated and analyzed the data, please see [Appendix B: PMV Methodology](#).

The following sections provide a summary of the results for the MCPs’ CY2025 PMV.

Summary of PMV Results

The MCPs met all NCQA IS standards and were in full compliance with the MY2024 HEDIS audit. Audit specifications confirmed that measure reporting processes followed NCQA requirements and aligned

with state specifications. All measures were determined to be fully reportable, providing reliable information for monitoring performance and supporting quality improvement.

Summary of HEDIS Measure Rates

Comagine Health compared MCP's performance on national HEDIS measures with national benchmarks published annually by NCQA in the *Quality Compass*®¹⁰ report with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid Health Maintenance Organization (HMO) plans and Medicaid HMO plans that are either required to report HEDIS measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS rates. The HEDIS measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all managed Medicaid plans. Also, note these plans represent states with and without Medicaid expansion coverage.

A licensing agreement with NCQA exists for all three measurement years reported – MY2022 through MY2024. The two benchmarks selected are the national 50th percentile and the national 75th percentile.

In addition to the national benchmarks, Comagine Health calculated the Medicaid State Rate (MSR) for each measure. The MSR for a given measure is calculated using the reported data from the four MCPs (HB, HSH, SMHK and UHC) for that measure. In order to determine the significance of year-to-year results, a Wilson Score Interval Test¹¹ was used to identify differences with a 95% confidence interval. This test was used for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the MCP or whether changes were due to normal variation.¹² For more information on interpreting results, see [Appendix B: PMV Methodology](#).

The results for each measure reported by the MCPs span MY2022 through MY2024. MY2024 results are then compared to the MY2024 MSR and to national state HMO Medicaid benchmarks at the 50th and 75th percentiles, with year-over-year changes analyzed for statistical significance. Findings are summarized below and categorized as “Strength,” “Compliant” or “Opportunity for Improvement” based on national percentiles (see scoring legend).

Recommendations are provided for all identified opportunities, followed by the issuance of an RA.

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 50th and 75th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

¹⁰ Quality Compass® is a registered trademark of NCQA.

¹¹ Note that past versions of this report used a Pearson's Chi Square test to identify year-over-year statistically significant changes. Upon review, Comagine Health determined the Wilson Score Interval is the more appropriate test for trended results.

¹² A Wilson Score Interval Test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance.

Promote Child Health



Promoting child health is essential to a child's overall well-being and development. Child health prevention and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality. Table 36 shows the Promote Child Health MCP Results.

Table 36. Promote Child Health MCP PMV Results.

Measure	MY2022 MSR	MY2023 MSR	MY2024 MSR	MY2024 50 th Percentile	MY2024 75 th Percentile	MY2024 HB Rate	MY2024 HSH Rate	MY2024 SMHK Rate	MY2024 UHC Rate
Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)	54.2%	56.9%	59.8% ▲	63.4%	67.5%	61.2% ▲	58.5%	63.6%	59.1% ▲
Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)	57.5%	60.0%	64.7% ▲	72.3%	77.5%	65.1% ▲	63.7% ▲	74.4%	63.9% ▲
Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV)	39.2%	43.5%	47.6% ▲	55.4%	61.5%	47.3% ▲	47.2% ▲	54.8% ▲	46.1% ▲
Oral Evaluation, Dental Services (0-20 Years) (Total) (OED)	NR*	NR*	45.0%	45.2%	51.3%	44.1%	45.2%	57.4%	42.5%
Childhood Immunization Status (Combo 10) (CIS)	21.4%	18.5%	21.7%	23.9%	28.9%	22.4%	16.5%	25.3% ▲	22.4%
Immunizations for Adolescents (13 Years) (Combo 2) (IMA)	22.6%	20.9%	24.8% ▲	36.5%	43.6%	24.1%	23.8%	30.9%	20.4%
Lead Screening in Children (LSC)	52.4%	57.9%**	68.4% ▲	70.0%	76.3%	62.3%	69.1% ▲	71.9% ▲	66.7% ▲

Statistically significant increase ▲

* Not Reported – The previous measure HEDIS measure, Annual Dental Visit, was retired in MY2022. The new OED measure was implemented in MY2023.

** Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review with the updated Wilson Score Interval test, SMHK showed no significant difference.

The measures reported by the MCPs for MY2022 through MY2024 are presented below. The accompanying graphs compare these measures against the MSR and national benchmarks at the 50th and 75th percentiles for each measure year reported.

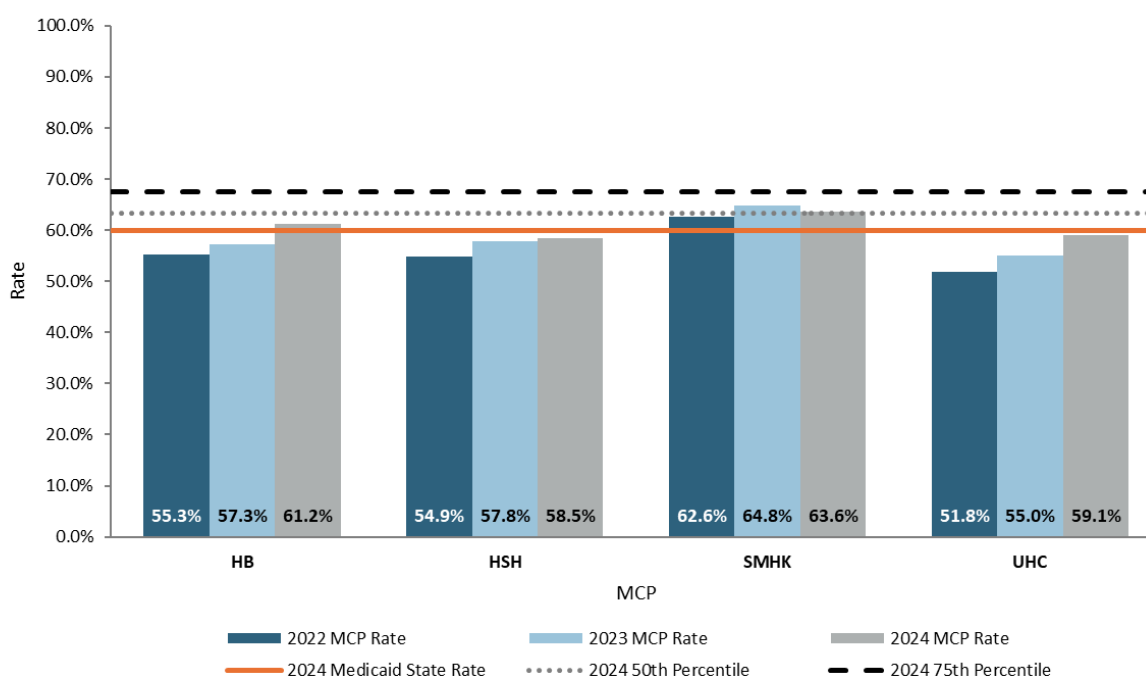
Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)

Figure 3 displays the results for *Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)*. This measure is the percentage of children who turned 15 months old during the measurement year and had six or more well-child visits.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 3. Well-Child Visits in First 30 Months of Life (0-15 Months) (W30).



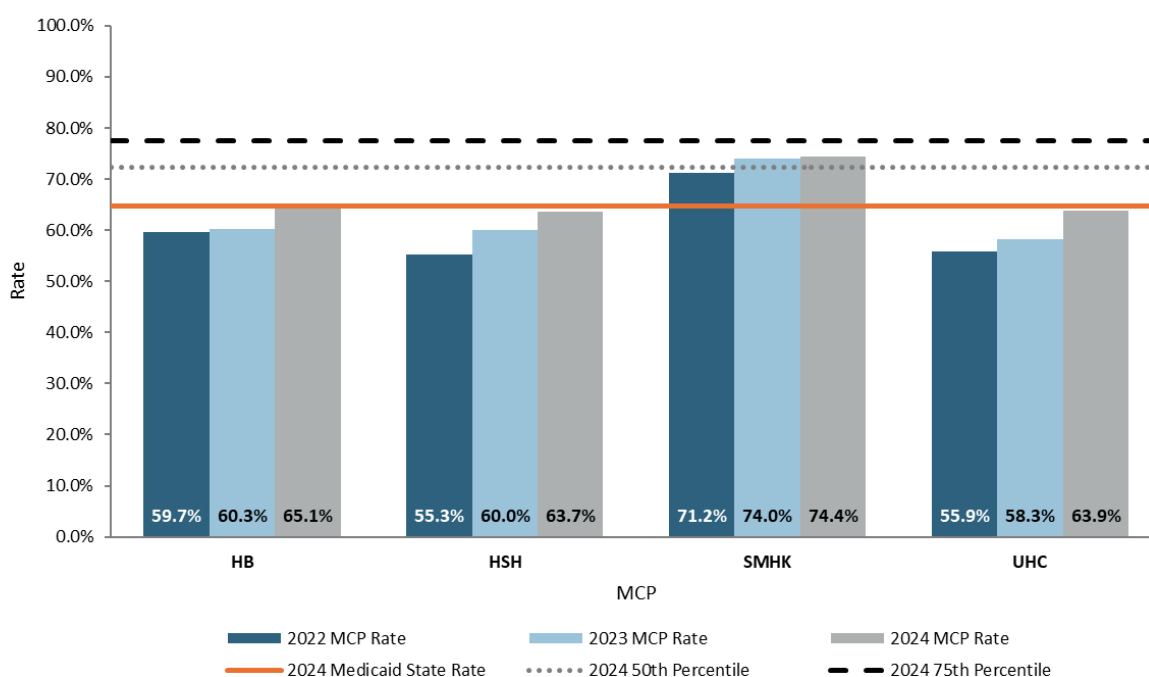
Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)

Figure 4 displays the results for *Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)*. This measure is the percentage of children who turned 30 months old during the measurement year and had two or more well-child visits.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 4. Well-Child Visits in First 30 Months of Life (15-30 Months) (W30).



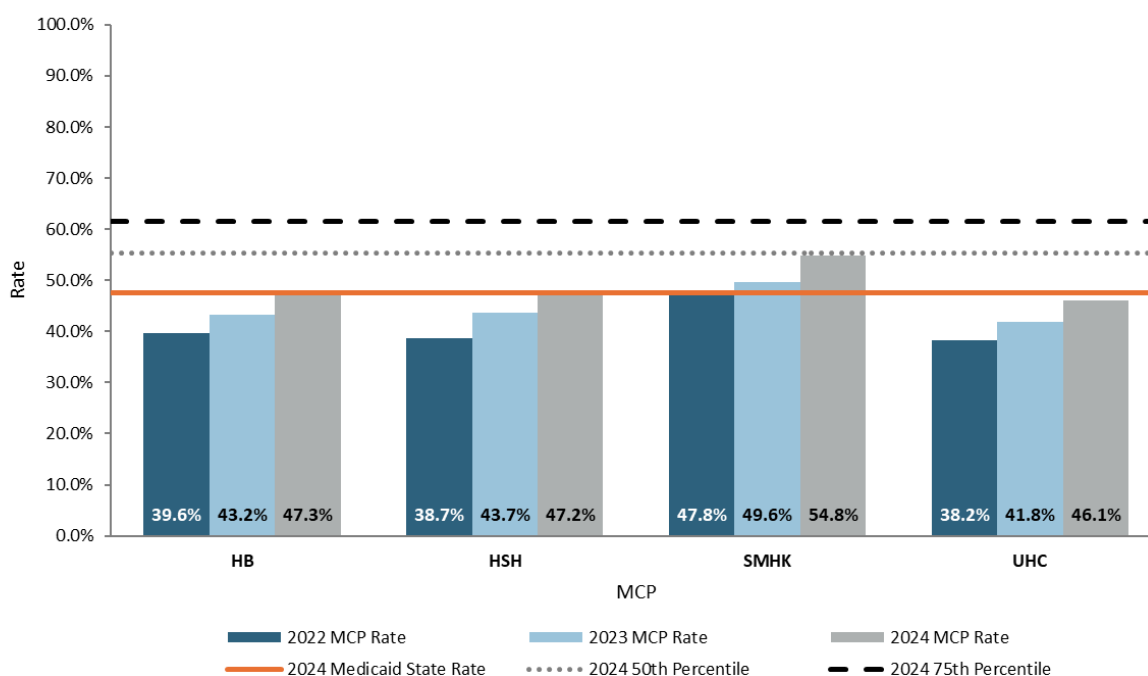
Child and Adolescent Well-Care Visits (3-21 years) (WCV)

Figure 5 displays the results for *Child and Adolescent Well-Care Visits (3-21 years) (WCV)*. This measure is the percentage of members ages 3-21 years old who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician-gynecologist (OB/GYN) practitioner during the measurement year.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 5. Child and Adolescent Well-Care Visits (3-21 Years) (WCV).



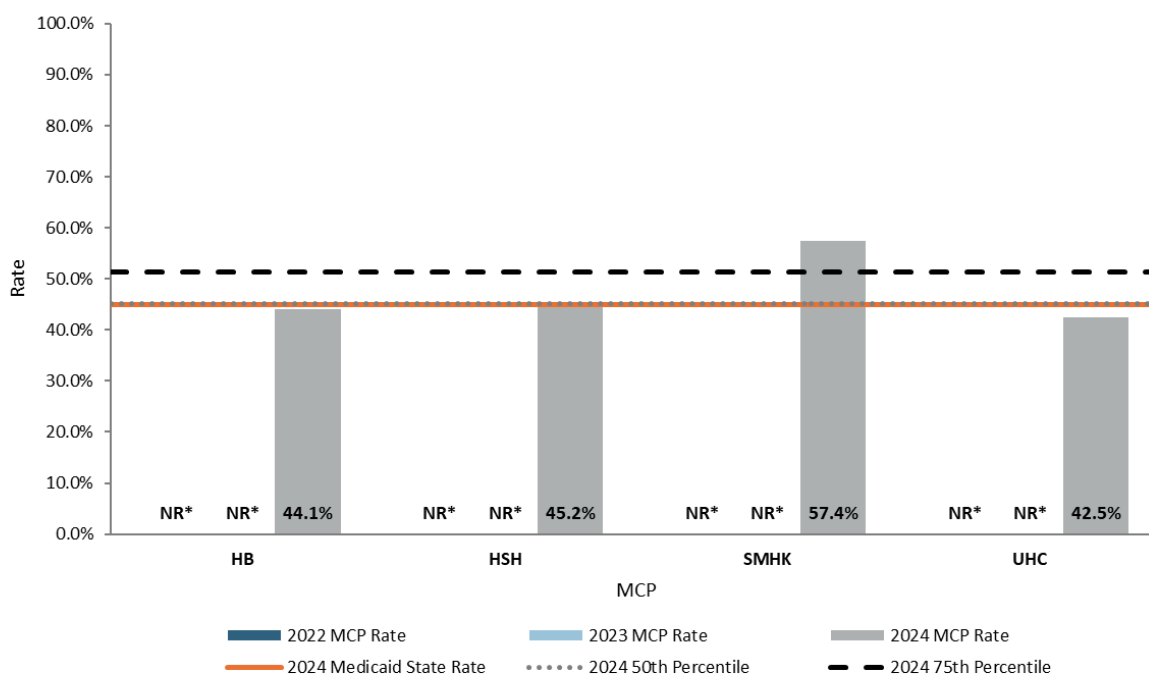
Oral Evaluation, Dental Services (>21 Years) (Total) (OED)

Figure 6 displays the results for *Oral Evaluation, Dental Services (>21 Years) (Total) (OED)*. This measure is the percentage of members age 0 to 20 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Results for the measure indicated opportunities for improvement in related practices to this measure.

The new OED measure was implemented in MY2023, therefore no analysis was completed.

Figure 6. Oral Evaluation, Dental Services (>21 Years) (Total) (OED).



**Not Reported – The previous measure HEDIS measure, Annual Dental Visit, was retired in MY2022. The new OED measure was implemented in MY2023.*

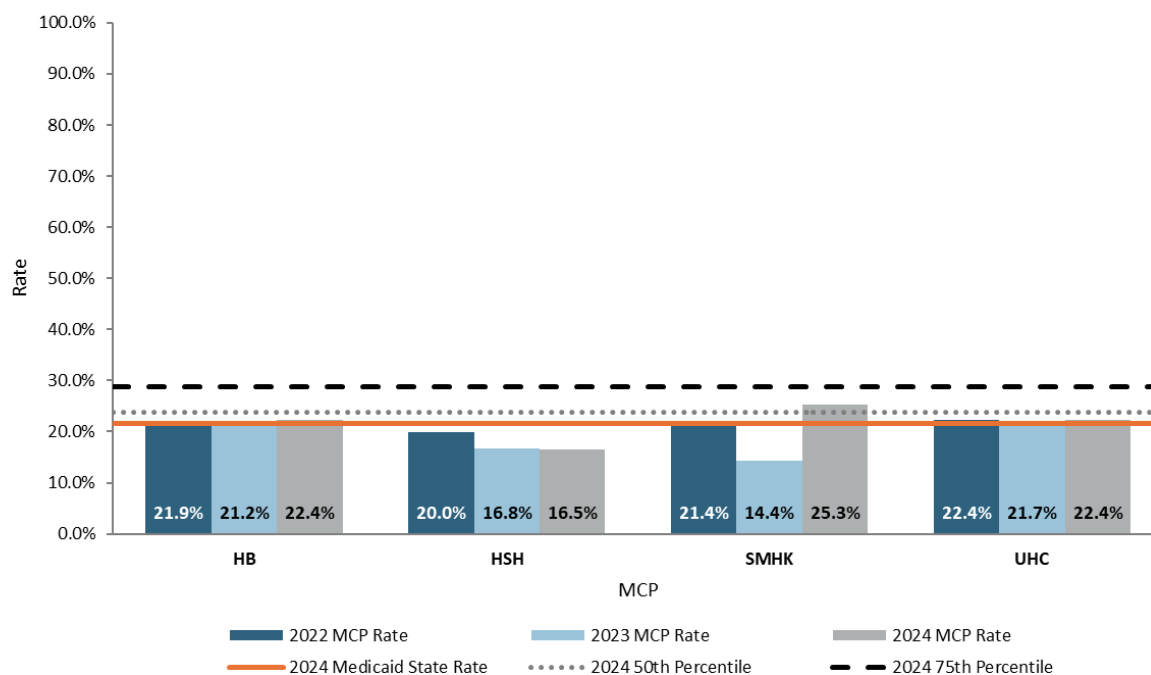
Childhood Immunization Status (Combo 10) (CIS)

Figure 7 displays the results for *Childhood Immunization Status (Combo 10) (CIS)*. This measure is the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated no statistically significant change between MY2023 and MY2024 to the MSR, which is likely to be the result of normal variation or chance.

Figure 7. Childhood Immunization Status (Combo 10) (CIS).



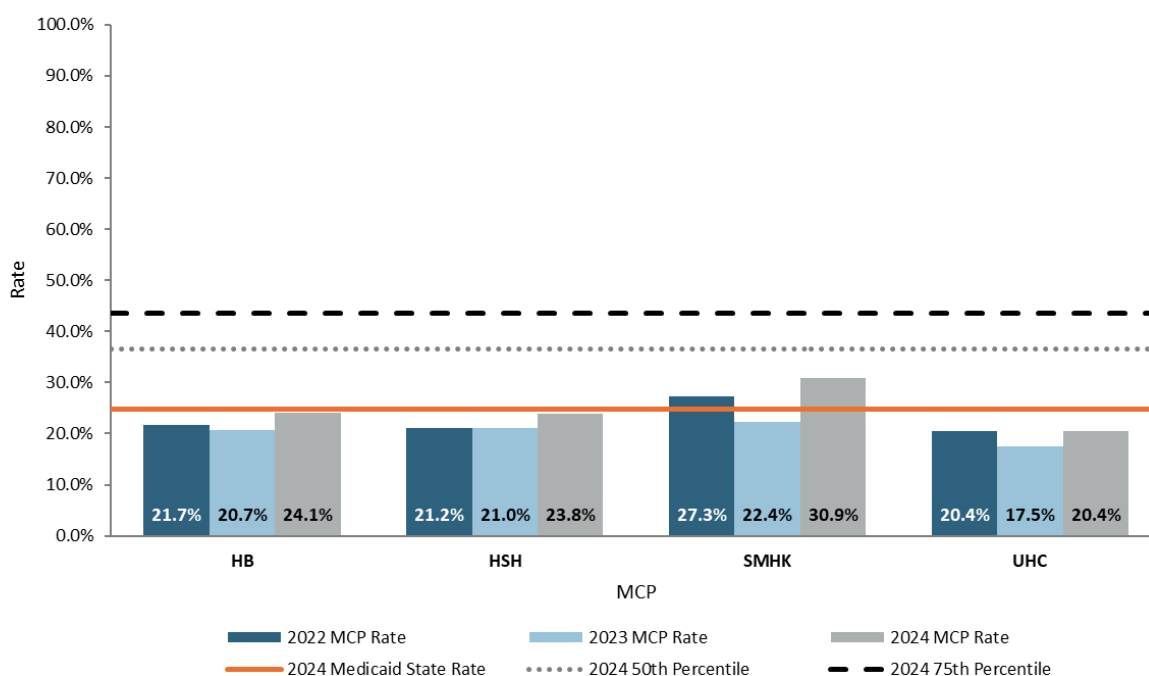
Immunizations for Adolescents (13 Years) (Combo 2) (IMA)

Figure 8 displays the results for *Immunizations for Adolescents (Combo 2) (IMA)*. This measure is the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 8. Immunizations for Adolescents (13 Years) (Combo 2) (IMA).



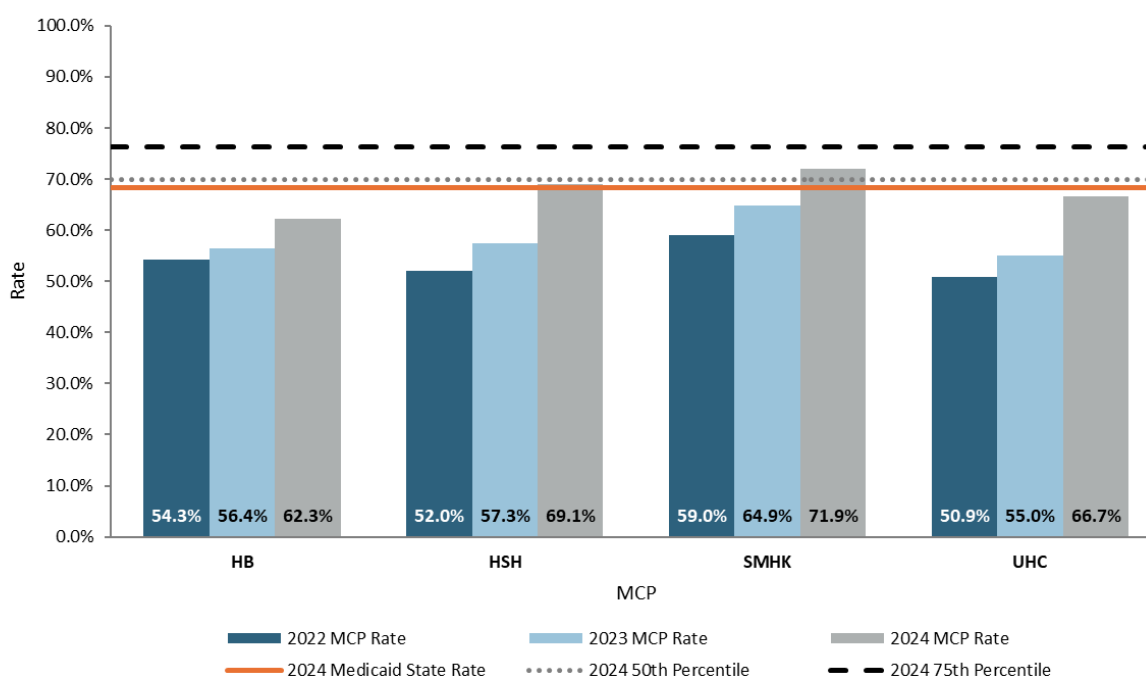
Lead Screening in Children (LSC)

Figure 9 displays the results for *Lead Screening in Children (LSC)*. This measure is the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 9. Lead Screening in Children (LSC).



Note: Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, SMHK showed no significant difference for MY2023.

Promote Chronic Disease Management



Chronic disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality.

Table 37 shows the Promote Chronic Disease Management MCP Results.

Table 37. Promote Chronic Disease Management MCP PMV Results.

Measure	MY2022 MSR	MY2023 MSR	MY2024 MSR	MY2024 50 th Percentile	MY2024 75 th Percentile	MY2024 HB Rate	MY2024 HSH Rate	MY2024 SMHK Rate	MY2024 UHC Rate
Asthma Medication Ratio (Total) (AMR)	54.7%	62.0%*	59.9% ▼	63.7%	70.4%	61.0% ▼	56.1% ▼	56.8% ▼	63.7% ▲
Glycemic Status Assessment for Patients with Diabetes (GSD) [Formally HBD]**	45.2%	53.0%†	57.4%	60.6%	64.7%	57.9%	59.4%	56.0%	55.2%
Controlling High Blood Pressure (CBP)	55.9%	59.1%	65.0% ▲	67.9%	71.3%	64.7%	66.2% ▲	63.0%	64.5%

Statistically significant increase ▲ / Statistically significant decrease ▼

* Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review with the updated Wilson Score Interval test, SMHK showed no significant difference for MY2023.

** Measure specifications for this measure were updated to allow other methods of glycemic status assessment in addition to HbA1c testing. NCQA has issued guidance to use caution when interpreting the results of this measure; year-over-year improvements may be due to the specifications change and not a true statistically significant change.

† Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review with the updated Wilson Score Interval test, HB, HSH and UHC showed no significant difference for MY2023.

The measures reported by the MCPs for MY2022 through MY2024 are presented below. The accompanying graphs compare these measures against the MSR and national benchmarks at the 50th and 75th percentiles for each measure year reported.

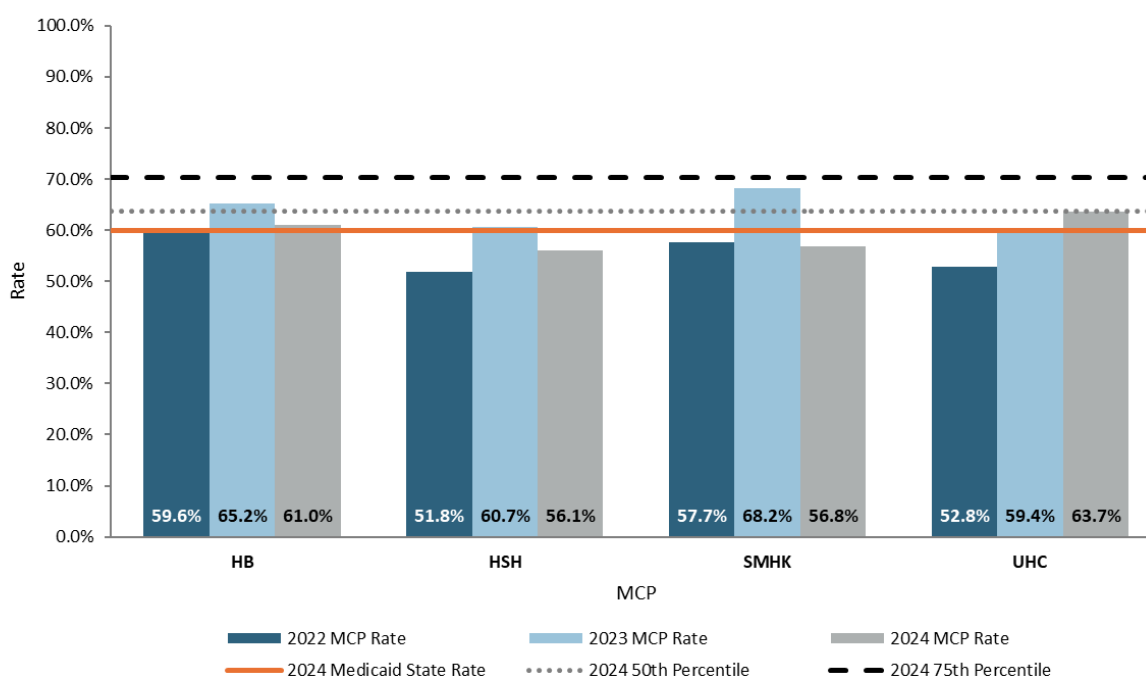
Asthma Medication Ratio (Total) (AMR)

Figure 10 displays the results for *Asthma Medication Ratio (Total) (AMR)*. This measure is the percentage of members five to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 10. Asthma Medication Ratio (Total) (AMR).



Note: Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, SMHK showed no significant difference for MY2023.

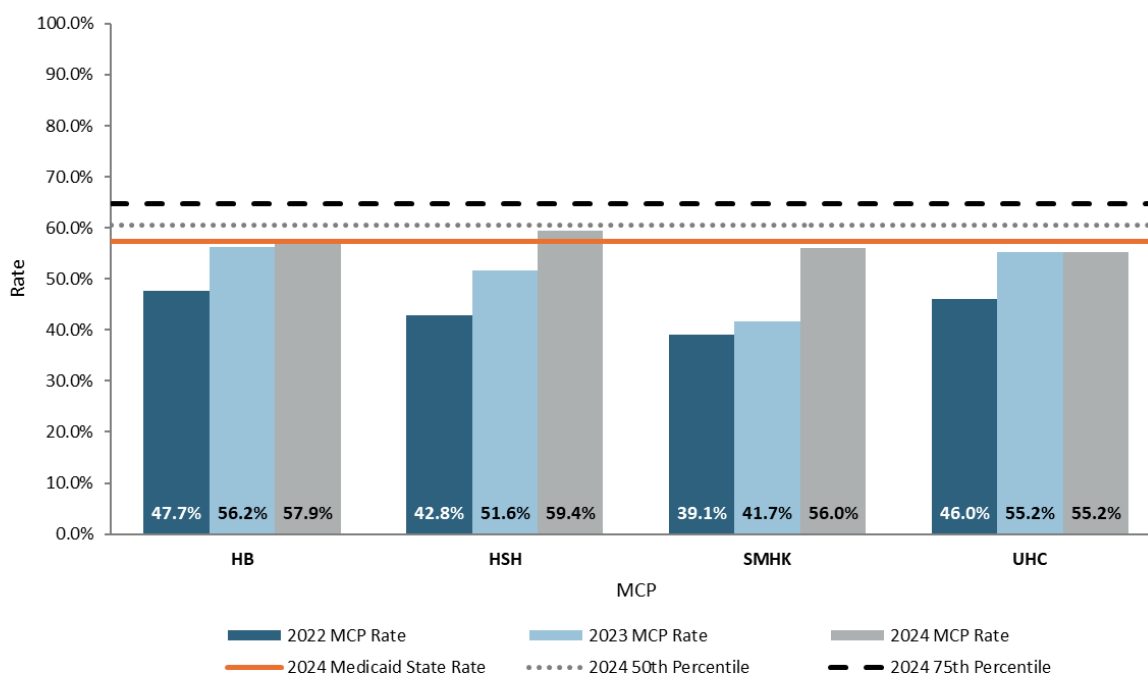
Glycemic Status Assessment for Patients with Diabetes (GSD), Hb1Ac Control 8%

Figure 11 displays the results for *Glycemic Status Assessment for Patients with Diabetes (GSD)*. This measure is the percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was <8.0%.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated no statistically significant change between MY2023 and MY2024 to the MSR, which is likely to be the result of normal variation or chance. The GSD measure specifications were updated to allow other methods of glycemic status assessment in addition to HbA1c testing. NCQA has issued guidance to use caution when interpreting the results of this measure; year-over-year improvements may be due to the specifications change and not a true statistically significant change.

Figure 11. Glycemic Status Assessment for Patients with Diabetes (GSD).



Note: Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review with the updated Wilson Score Interval test, HB, HSH and UHC showed no significant difference for MY2023.

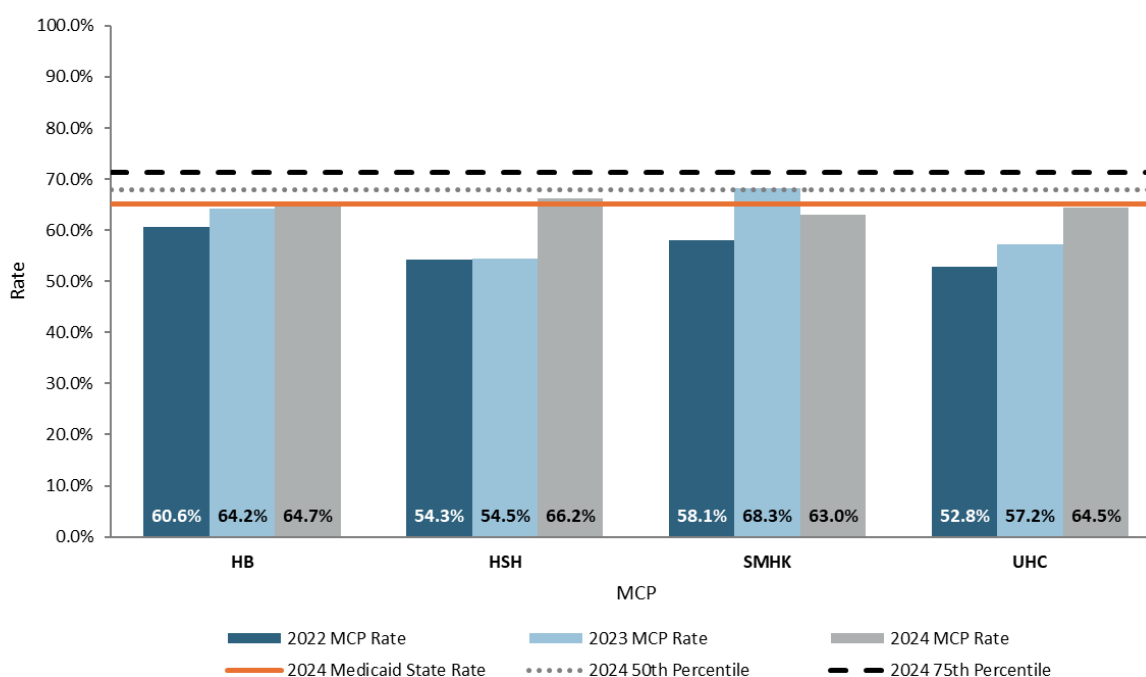
Controlling High Blood Pressure (CBP)

Figure 12 displays the results for *Controlling High Blood Pressure (CBP)*. This measure is the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 12. Controlling High Blood Pressure (CBP).



Promote Women's Health



Women's health prevention and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. Also included in this section are measures related to adequate prenatal and postpartum care, which are essential for positive pregnancy outcomes. These measures reflect access and quality.

Table 38 shows the Promote Women's Health MCP Results.

Table 38. Promote Women's Health MCP PMV Results.

Measure	MY2022 MSR	MY2023 MSR	MY2024 MSR	MY2024 50 th Percentile	MY2024 75 th Percentile	MY2024 HB Rate	MY2024 HSH Rate	MY2024 SMHK Rate	MY2024 UHC Rate
Timeliness of Prenatal Care (PPC)	84.8%	83.7%	85.9%	86.4%	89.8%	87.8%	87.8% ▲	79.2%	87.3%
Postpartum Care (PPC)	75.2%	77.6%	78.6%	82.5%	85.2%	79.8%	78.3%	74.5%	81.0%
Chlamydia Screening in Women (Total) (CHL)	46.5%	47.8%*	43.7% ▼	56.3%	65.5%	38.0%	47.7% ▼	49.2% ▼	45.5% ▼

Statistically significant increase ▲ / Statistically significant decrease ▼

*Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, UHC showed no significant difference for MY2023.

The measures reported by the MCPs for MY2022 through MY2024 are presented below. The accompanying graphs compare these measures against the MSR and national benchmarks at the 50th and 75th percentiles for each measure year reported.

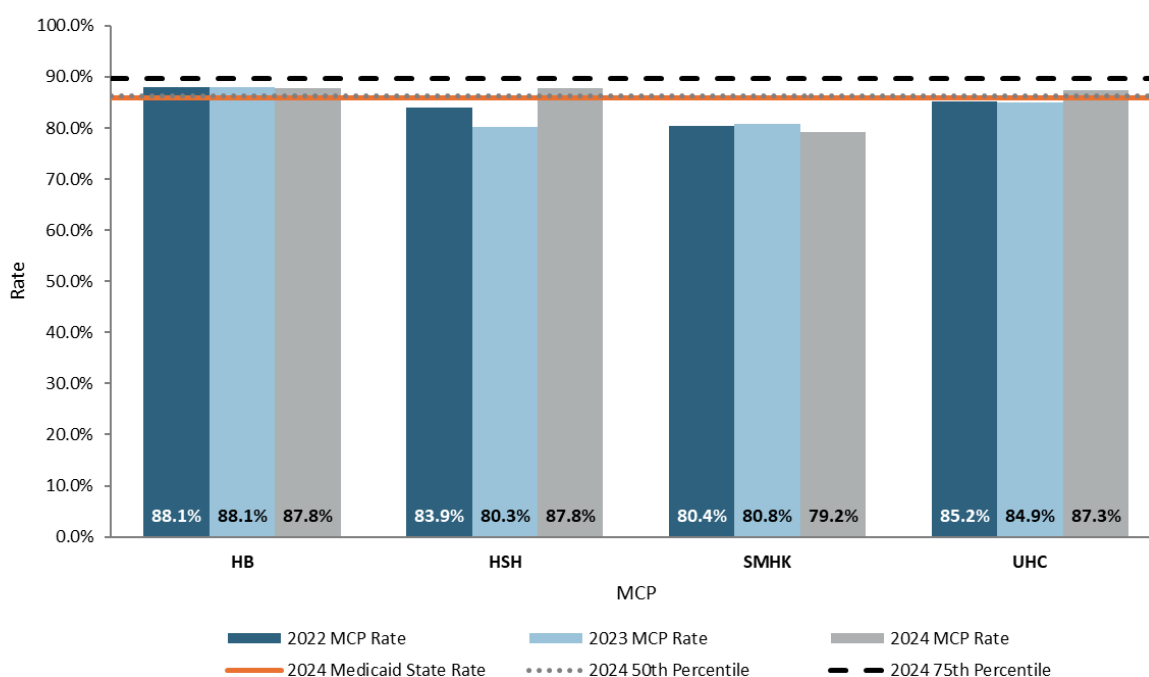
Timeliness of Prenatal Care (PPC)

Figure 13 displays the results for Timeliness of Prenatal Care (PPC). This measure is the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated no statistically significant change between MY2023 and MY2024 to the MSR, which is likely to be the result of normal variation or chance.

Figure 13. Timeliness of Prenatal Care (PPC).



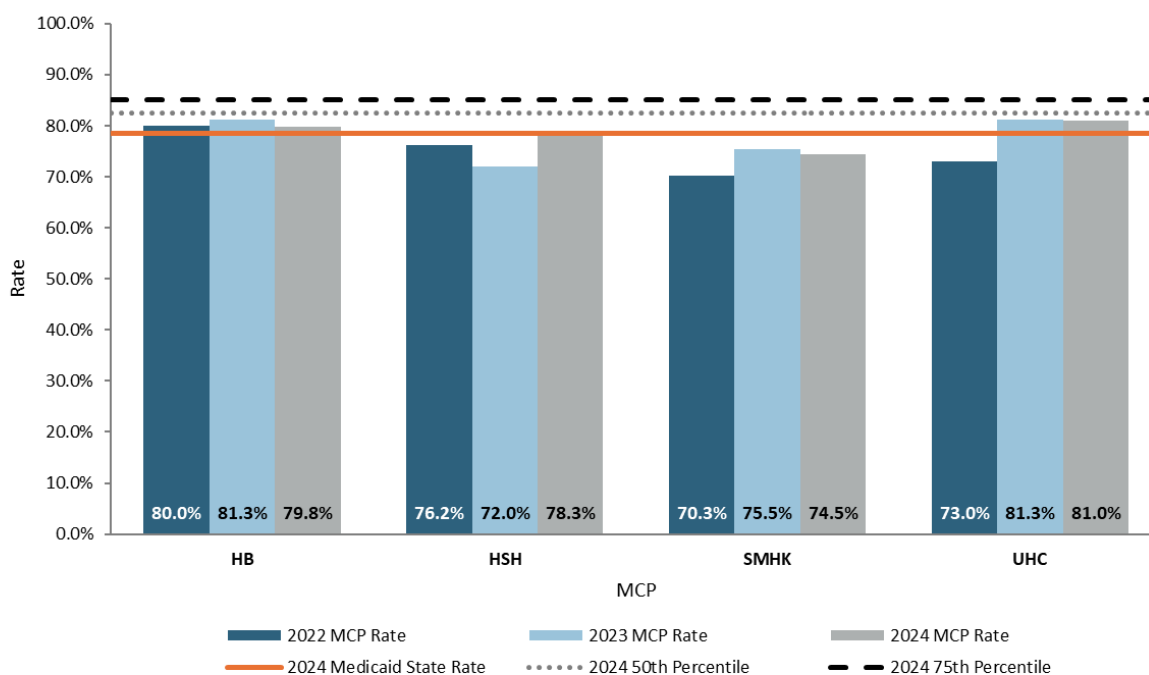
Postpartum Care (PPC)

Figure 14 displays the results for Postpartum Care (PPC). This measure is the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated no statistically significant change between MY2023 and MY2024 to the MSR, which is likely to be the result of normal variation or chance.

Figure 14. Postpartum Care (PPC).



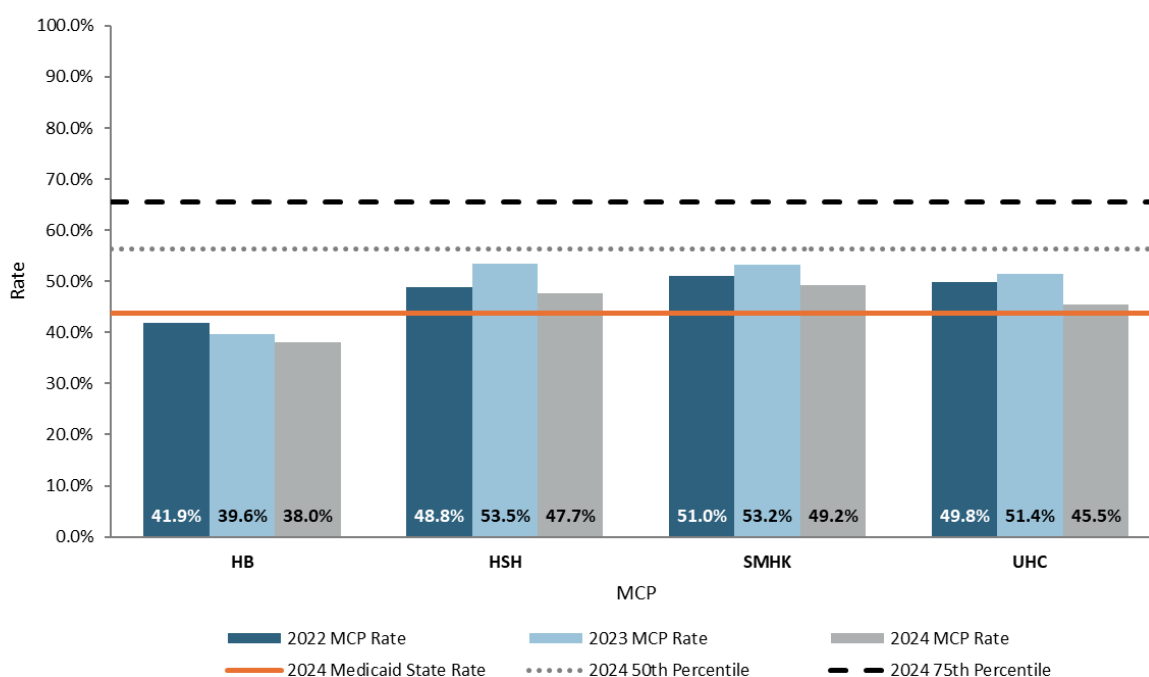
Chlamydia Screening in Women (Total) (CHL)

Figure 15 displays the results for Chlamydia Screening in Women (Total) (CHL). This measure is the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 15. Chlamydia Screening in Women (Total) (CHL).



Note: Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, UHC showed no significant difference for MY2023.

Improve Management of Behavioral Health and Substance Use Disorder



Improving the management of behavioral health and substance use disorders involves comprehensive strategies to enhance care, support and outcomes for individuals facing mental health conditions and substance-related challenges. The measure for timely follow-up after hospitalization for mental illness ensures that enrollees who have been hospitalized due to a mental health issue receive adequate follow-up in an outpatient setting. This measure reflects timeliness, access and quality.

Table 39 shows the Improve Management of BH and SUD MCP Results.

Table 39. Improve Management of BH and SUD Rate MCP PMV Results.

Measure	MY2022 MSR	MY2023 MSR	MY2024 MSR	MY2024 50 th percentile	MY2024 75 th Percentile	MY2024 HB Rate	MY2024 HSH Rate	MY2024 SMHK Rate	MY2024 UHC Rate
Follow-Up After Hospitalization for Mental Illness (30 Days) (Total) (FUH)	53.3%	54.0%*	57.7% ▲	62.1%	70.6%	54.9%	54.1%	78.9% ▲	49.4% ▲
Follow – Up after Emergency Department Visit for Mental Illness (30 Days) (Total) (FUM)	NR**	NR**	46.9%	57.1%	64.9%	44.6%	44.3%	64.7%	42.6%

Statistically significant increase ▲

* Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, the overall state rate showed no significant difference for MY2023.

**Not Reported – FUM is being reported for the first time in MY2024. Historical data was not collected for this measure.

The measures reported by MCPs for MY2022 through MY2024 are presented below. The accompanying graphs compare these measures against the MSR and national benchmarks at the 50th and 75th percentiles for each measure year reported.

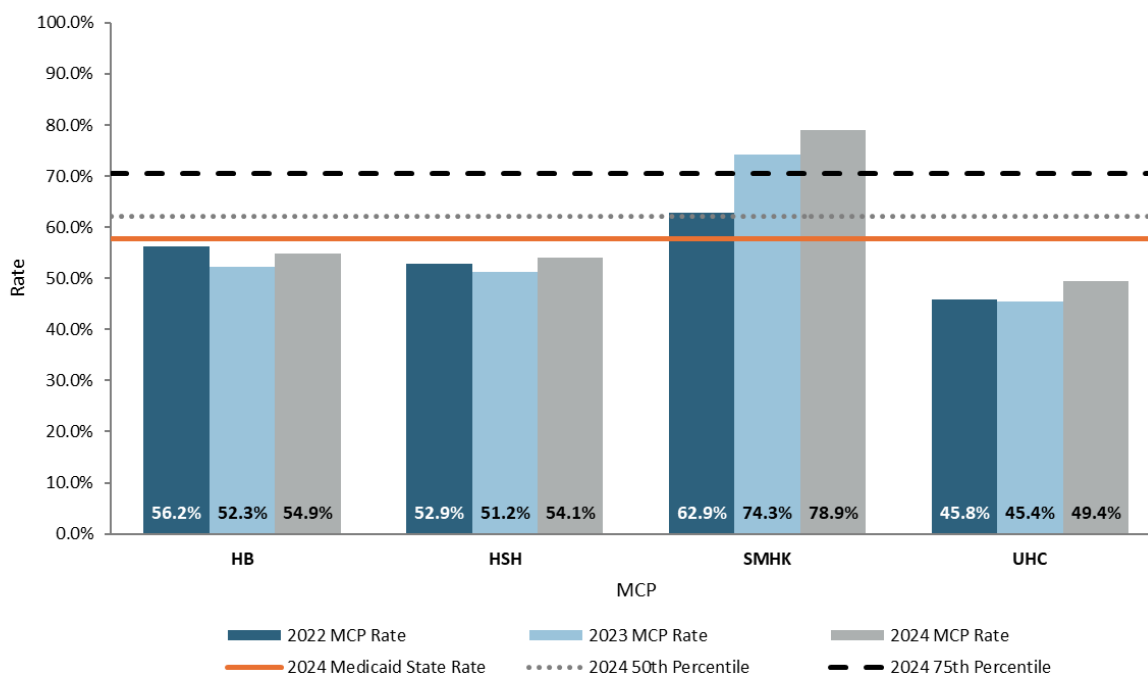
Follow-Up After Hospitalization for Mental Illness (FUH 30-day)

Figure 16 displays the results for Follow-Up After Hospitalization for Mental Illness (30 Days) (FUH). This measure is the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.

Results for the measure indicated opportunities for improvement in related practices to this measure.

Analysis indicated a statistically significant change between MY2023 and MY2024 to the MSR, which is unlikely to be the result of normal variation or chance.

Figure 16. Follow-Up After Hospitalization for Mental Illness (30 Days) (FUH).



Note: Earlier reports used Pearson's Chi Square tests to detect statistical significance changes, but after review, with the updated Wilson Score Interval test, the overall state rate showed no significant difference for MY2023.

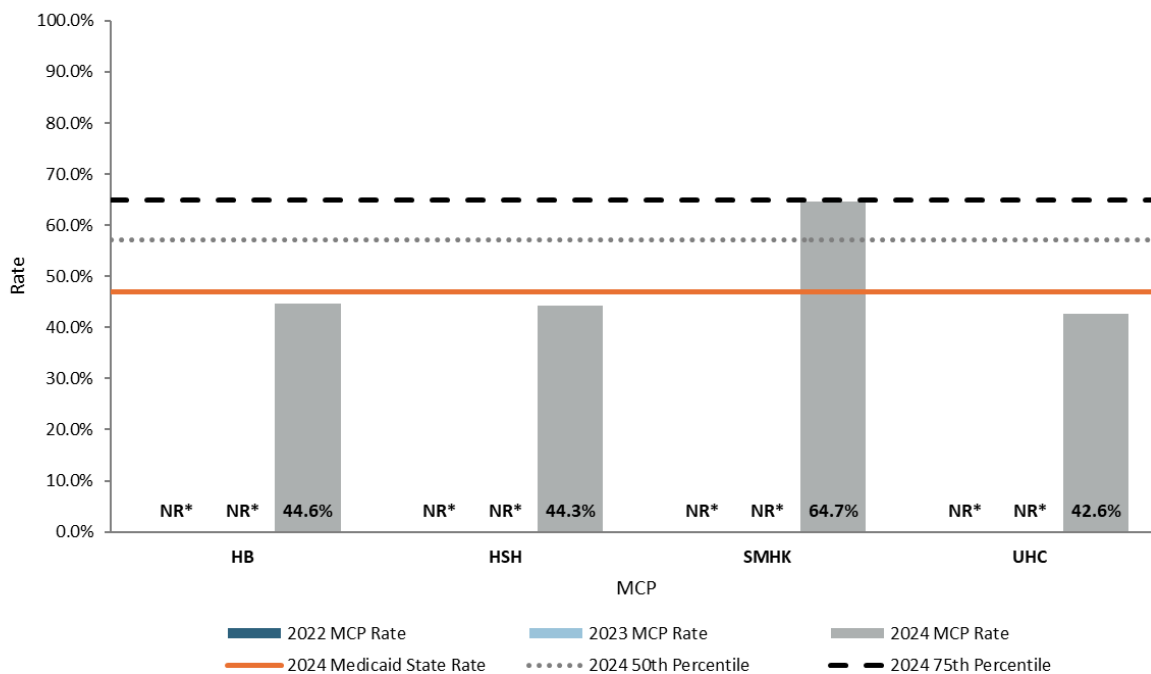
Follow-Up After Emergency Department Visit for Mental Illness (30 Days) (FUM)

Figure 17 displays the results for Follow-Up After Emergency Department Visit for Mental Illness (30 Days) (FUM). This measure is the percentage of discharges for members six years of age with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the emergency department discharge.

Results for the measure indicated opportunities for improvement in related practices to this measure.

FUM is being reported for the first time in MY2024. Historical data was not collected for this measure, therefore no analysis was completed.

Figure 17. Follow-Up After Emergency Department Visit for Mental Illness (30 Days) (FUM).



**Not Reported – FUM is being reported for the first time in MY2024. Historical data was not collected for this measure.*

Program Level EQRO PMV Recommendations

Based on the program level findings from the PMV review, the following recommendation is provided to MHD for improving measure results. Recommendations were given for those measure rates below the 50th percentile.

- MHD should work with the MCPs to conduct a root cause analysis to identify barriers contributing to performance, as all measures reported MSR rates below the 50th percentile.

An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

Progress on Previous Year (2024) Program Level EQRO PMV Recommendations

Table 40 presents the EQRO recommendations from the previous review alongside the actions implemented by MHD.

Table 40. PMV Program Level Progress on 2024 Recommendations.

EQRO Recommendation
MHD should work with the MCPs to: • Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures. • Identify and continue the improvement efforts that are driving significant improvement in the following measures: ○ Annual Dental Visits (Total) (ADV) ○ Asthma Medication Ratio (Total) (AMR) ○ Lead Screening in Children (LSC) ○ Follow-Up After Hospitalization for Mental Illness (FUH 30-day) ○ Chlamydia Screening in Women (Total) (CHL) • Conduct a root cause analysis to identify barriers to improving the following measures: ○ Childhood Immunization Status (Combo 10) (CIS) and Immunizations for Adolescents (Combo 1) (IMA) ○ Postpartum Care (PPC)
MHD Response
To foster transparency and shared learning, MHD required MCPs to present their PMV findings – including challenges and best practices – during the 2025 Spring Quality Assessment and Improvement session. These presentations offered insights into plan-specific improvement strategies and created opportunities for peer-to-peer exchange. MHD is actively documenting MCP-initiated efforts and exploring how PMV findings can inform future quality improvement opportunities. MY2024 HEDIS rates show improvement compared to the prior year but still fall short of national medians. MHD will continue to set performance targets that are reasonably achievable but drive performance until they meet and exceed performance goals.
EQRO Response
In CY2025, many measures showed improvement; however, all measures remain an opportunity for continued focus. MHD should continue to work with the MCPs to identify barriers contributing to performance. The response is accepted.

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Summary of Plan Level PMV Findings

Table 41, Table 42, Table 43 and Table 44 provide an overview of each MCP's findings. Strengths were given for those measure rates at or above the 75th percentile, while recommendations were given for those measure rates at or below the 50th percentile. An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

For more detailed information on the findings, please refer to the individual [MCP 2025 EQR PMV reports](#).

Healthy Blue

Table 41. HB PMV Findings.

HB PMV Findings
Strengths
No strengths were identified in this year's review.
Recommendations Based on Weaknesses/Opportunities for Improvement
Promote Child Health - Identify and continue the improvement efforts that are driving significant improvement in the following measures: - Both W30 measures - Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV) - Childhood Immunization Status (Combo 10) (CIS) - Immunizations for Adolescents (13 Years) (Combo 2) (IMA) - Lead Screening in Children (LSC) - Conduct a root cause analysis to identify barriers to improving the (OED) measure.
Promote Chronic Disease Management - Identify and continue the improvement efforts that are driving significant improvement in the following measures: - Glycemic Status Assessment for Patients with Diabetes (GSD), HbA1c Control <8% - Controlling High Blood Pressure (CBP) - Conduct a root cause analysis to identify barriers to improving the (AMR) measure.
Promote Women's Health - Conduct a root cause analysis to identify barriers to improving the (CHL) measure. - Conduct a root cause analysis to identify barriers to improving the Postpartum Care (PPC) measure.
Improve Management of Behavioral Health and Substance Use Disorder - Identify and continue the improvement efforts that are driving significant improvement in the (FUH) measure. - Conduct a root cause analysis to identify barriers to improving the (FUM) measure.

Home State Health**Table 42. HSH PMV Findings.**

HSH PMV Findings
Strengths
No strengths were identified in this year's review.
Recommendations Based on Weaknesses/Opportunities for Improvement
Promote Child Health - Identify and continue the improvement efforts that are driving significant improvement in the following measures: - Both W30 measures - Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV) - Immunizations for Adolescents (13 Years) (Combo 2) (IMA) - Lead Screening in Children (LSC) - Conduct a root cause analysis to identify barriers to improving the CIS measure.
Promote Chronic Disease Management - Identify and continue the improvement efforts that are driving significant improvement in the following measures: - Glycemic Status Assessment for Patients with Diabetes (GSD), HbA1c Control <8% - Controlling High Blood Pressure (CBP) - Conduct a root cause analysis to identify barriers to improving the AMR measure.
Promote Women's Health - Identify and continue the improvement efforts that are driving significant improvement in the PPC measure. - Conduct a root cause analysis to identify barriers to improving the CHL measure.
Improve Management of Behavioral Health and Substance Use Disorder - Identify and continue the improvement efforts that are driving significant improvement in the FUH measure. - Conduct a root cause analysis to identify barriers to improving the FUM measure.

Show Me Healthy Kids**Table 43. SMHK PMV Findings.**

SMHK PMV Findings
Strengths
- Oral Evaluation, Dental Services (Total) (OED) - Follow-Up After Hospitalization for Mental Illness (30 Days) (Total) (FUH)
Recommendations Based on Weaknesses/Opportunities for Improvement
Promote Child Health - Identify and continue the improvement efforts that are driving significant improvement in the following measures: - Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV) - Immunizations for Adolescents (13 Years) (Combo 2) (IMA)
Promote Chronic Disease Management Identify and continue the improvement efforts that are driving significant improvement in the

SMHK PMV Findings

GSD measure.

- Conduct a root cause analysis to identify barriers to improving the following measures:
 - Asthma Medication Ratio (Total) (AMR)
 - Controlling High Blood Pressure (CBP)

Promote Women's Health

- Conduct a root cause analysis to identify barriers to improving the following measures:
 - Timeliness of Prenatal Care (PPC)
 - Postpartum Care (PPC)
 - Chlamydia Screening in Women (Total) (CHL)

UnitedHealthcare**Table 44. UHC PMV Findings.****UHC PMV Findings****Strengths**

- No strengths were identified in this year's review.

Recommendations Based on Weaknesses/Opportunities for Improvement**Promote Child Health**

- Identify and continue the improvement efforts that are driving significant improvement in the following measures:
 - Both W30 measures
 - Child and Adolescent Well-Care Visits (3-21 Years) (Total) (WCV)
 - Childhood Immunization Status (Combo 10) (CIS)
 - Immunizations for Adolescents (13 Years) (Combo 2) (IMA)
 - Lead Screening in Children (LSC)
- Conduct a root cause analysis to identify barriers to improving the OED measure

Promote Chronic Disease Management

- Identify and continue the improvement efforts that are driving significant improvement in the following measures:
 - Glycemic Status Assessment for Patients with Diabetes (GSD), HbA1c Control <8%
 - Controlling High Blood Pressure (CBP)

Promote Women's Health

- Conduct a root cause analysis to identify barriers to improving the following measures:
 - Postpartum Care (PPC)
 - Chlamydia Screening in Women (Total) (CHL)

Improve Management of Behavioral Health and Substance Use Disorder

- Identify and continue the improvement efforts that are driving significant improvement in the FUH measure
- Conduct a root cause analysis to identify barriers to improving the FUM measure

Progress on Previous Year (2024) Plan Level EQRO PMV Recommendations

Table 45 presents the plan level EQRO recommendations from the previous review, along with the degree to which plans have addressed the previous year's EQRO recommendations. The MCPs' efforts to address these recommendations were assessed through the RA process, formerly known as a corrective action plan, during the current review period and are summarized below. MCP-specific progress is provided in the individual [MCP 2025 PMV reports](#).

Key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Table 45. PMV Plan Level Progress on 2024 Recommendations – Count and Degree Assessed.

MCP	Total Received	Met	Not Met	Degree to which plans addressed all EQRO recommendation(s)
HB	13	10	3	Medium
HSH	14	11	3	Medium
SMHK	6	4	2	Medium
UHC	13	11	2	Medium

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Compliance with Standards Review

Objective

The purpose of the compliance review is to determine whether Medicaid managed care plans are following federal standards. CMS developed mandatory standards for MCPs which are codified at 42 CFR 438¹³ and 42 CFR 457,¹⁴ as revised by the Medicaid and CHIP managed care final rule issued in 2016. For this mandatory EQR activity, MetaStar, under contract with Comagine Health, completed the compliance review.

Overview



Federal regulations require MCPs to have undergone a review within the three-year period preceding each annual EQR to determine MCP compliance with federal standards as implemented by the state.

MHD and Comagine Health have chosen to spread the review over a three-year cycle (2024-2026) as shown in Table 46. CHIP citations are included in this table for informational purposes. The citations for the managed care rule will be used throughout the report. Note: these standards fall under the domains of quality, access and timeliness of health care and services.

Table 46. Principal Compliance Standards Reviewed in the Current Cycle (2024-2026).

EQR Cycle Year	42 CFR 438 (Managed Care)	42 CFR 457 (CHIP)	Standard Name
Year 1	§438.56	§457.1212	Disenrollment: Requirements and limitations
Year 1	§438.100	§457.1220	Enrollee rights and protections
Year 1	§438.114	§457.1228	Emergency and post-stabilization services
Year 1	§438.206	§457.1230(a)	Availability of services
Year 1	§438.207	§457.1230(b)	Assurances of adequate capacity and services
Year 1	§438.208	§457.1230(c)	Coordination and continuity of care
Year 1	§438.210	§457.1230(d)	Coverage and authorization of services
Year 1	§438.214	§457.1233(a)	Provider selection
Year 1	§438.224	§457.1230(c)	Confidentiality
Year 1	§438.230	§457.1233(b)	Subcontractual relationships and delegation
Year 1	§438.236	§457.1233(c)	Practice guidelines
Year 1	§438.242	§457.1233(d)	Health information systems
Year 2*	§438.228	§457.1260	Grievance and appeal systems
Year 3	§438.330	§457.1240(b)	Quality assessment and performance improvement program

*Standards reviewed in the current year.

¹³ Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available at: <https://www.ecfr.gov/current/title-42/part-438>.

¹⁴ Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5>.

Methodology

The compliance review followed the guidelines from CMS, *EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*. This protocol provides a structured framework for evaluating how MCPs adhere to federal requirements, ensuring they meet standards for quality, access and timeliness of health care and services.

Scoring

Each standard has a specified number of scoring elements, which correlate with federal standards and MHD contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 3.

For a full description of the methodology, including technical methods of data collection, description of data obtained and how the data was aggregated and analyzed, please see [Appendix C: Compliance Methodology](#).

Summary of Compliance Results

Table 47 shows the scoring key for compliance as expressed in terms of a percentage score and compliance rating.

Table 47. Compliance Rating Legend.

Score	Compliance Rating
90% - 100%	Fully Met
80% - 89.9%	Substantially Met
70% - 79.9%	Partially Met
60% - 69.9%	Minimally Met
≤ 59.9%	Not Met

Table 48 summarizes all MCPs and provides an aggregate overview (MO) of their compliance results at the program level for Year 2 of the current three-year cycle. Plans with elements scored as “Partially Met” or “Not Met” were required to submit RAs to Comagine Health.

Plans were scored on these elements in the first half of the calendar year. Because MCPs may have implemented RAs since that time to address specific issues, scores may not be indicative of current performance.

Table 48. Individual MCP Compliance and Program Level Results.

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO
G1	§438.228 – Grievance and appeal systems	33.3%	100%	100%	100%	83.3%
G2	§438.402 – General requirements	85.7%	100%	100%	100%	96.4%
G3	§438.404 – Timely and adequate notice of adverse benefit determination	87.5%	100%	100%	100%	96.9%
G4	§438.406 – Handling of grievances and appeals	90.0%	90.0%	90.0%	100%	92.5%

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO
G5	§438.408 – Resolution and notification, grievances and appeals	85.7%	85.7%	85.7%	85.7%	85.7%
G6	§438.410 – Expedited resolution of appeals	50.0%	100%	100%	100%	87.5%
G7	§438.414 – Information about the grievance and appeal system to providers and subcontractor	100%	100%	100%	100%	100%
G8	§438.416 – Recordkeeping requirements	100%	100%	100%	100%	100%
G9	§438.420 – Continuation of benefits while the MCO, PIHP or PAHP appeal and the state Fair Hearing are pending	75.0%	75.0%	75.0%	100%	81.3%
G10	§438.424 – Effectuation of reversed appeal resolution	66.7%	100%	100%	100%	91.7%

Program Level Compliance EQRO Recommendations

Based on the program level findings from the compliance with standards review, weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements.

- Grievance and appeals systems (83.3%) **(G1)**
 - One of the four MCPs scored 33.3% on this standard.
- Resolution and notification, grievances and appeals (85.7%) **(G5)**
 - All four MCPs scored 85.7% on this standard.
- Expedited resolution and appeals (87.5%) **(G6)**
 - One of the four MCPs scored 50.0% on this standard.
- Continuation of benefits while the MCO, PIHP or PAHP appeal and the state Fair Hearing are pending (81.3%) **(G9)**
 - Three of the four MCPs scored 75.0% on this standard.

An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

Progress on Previous Year (2024) Program Level Compliance EQRO Recommendations

Table 49 presents the EQRO recommendations from the previous review alongside the actions implemented by MHD.

Table 49. Compliance Program Level Progress on 2024 Recommendations.

EQRO Recommendation
The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements. • Additional coordination and continuity of care requirements (81.8%) (M6) ○ Two of the four MCPs scored 50.0% on this standard. • Information requirements for all enrollees (81.8%) (M9) ○ Two of the four MCPs scored 72.7% on this standard. • Enrollee right to receive information on available provider options (75.0%) (M10) ○ Three of the four MCPs received a score of 66.7% on this standard. • Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint (76.2%) (M11) ○ Two of the four MCPs received a score of 60.0% or below on this standard. • Compliance with other federal and state laws (75.0%) (M12) ○ One of the four MCPs received a score of 0.0% on this standard. • Provider selection (86.1%) (M13) ○ Three of the four MCPs scored below 90.0% on this standard. • Practice Guidelines (85.0%) (M15) ○ Three of the four MCPs received a score of 80% on this standard.
MHD Response
MHD has taken steps to identify any outstanding gaps – these gaps will continue to be monitored in an effort to address any outstanding performance issues. Clarification of expectations and ongoing communication will continue as MHD monitors MCP improvement across key compliance areas. MHD is committed to continuous quality assurance and ongoing engagement with MCPs to foster consistent compliance and performance excellence across all domains.
EQRO Response
The EQRO acknowledges MHD’s work in addressing the recommendation. The response is accepted.

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Summary of Plan Level Compliance Findings

Based on the plan level findings from the compliance with standards review, strengths are given for standards that scored at or above 90%, as well as practices identified through the provider file verification. Weaknesses or opportunities for improvement are included for any standard that is below 90% and any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement, followed by the issuance of an RA. An update of the current year’s EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

The following provides an overview of the individual compliance findings for the MCPs. For more detailed information on the findings, please refer to the [MCP 2025 EQR Compliance with Standards reports](#).

Healthy Blue

Table 50 and Table 51 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HB.

Table 50. HB: Compliance Strengths.

Strengths
- HB complied with requirements for handling grievances and appeals, including acknowledgement, local committee composition and requirements and special requirements for appeals. HB demonstrated compliance through documentation submitted, the interview session with HB staff and a verification of a sample of HB's local grievances and appeals filed in 2024. The verification activity demonstrated appropriate handling of grievances and appeals (G4). - HB provided information about the grievance and appeal system to providers and subcontractors. Documentation submitted and the interview with HB staff confirmed practices are in place (G7). - HB complied with record keeping requirements for grievances and appeals. Records submitted included all required criteria (G8).

Table 51. HB: Compliance Recommendations.

Recommendations Based on Weaknesses/Opportunities for Improvement
- Create and maintain a training plan or system to ensure that applicable staff have received training on the plan's grievance and appeal systems. Training provides assurance that regulatory compliance is implemented and sustained (G1, G2, G4, G5, G6, G9, G10 Training). - Ensure that all requirements for education materials related to grievance and appeal systems are included in internal policy and procedure documents (G1.2). - Create and maintain a training plan or system to ensure that applicable staff have received training on the requirements for issuing timely and adequate <i>Notices of Adverse Benefit Determination</i>. Training provides assurance that regulatory compliance is implemented and sustained (G3 Training).

Home State Health

Table 52 and Table 53 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HSH.

Table 52. HSH: Compliance Strengths.

Strengths
- HSH had a grievance and appeal system in place that includes an internal grievance process, an appeal process and access to the state's Fair Hearing system. HSH demonstrated compliance through documentation submitted and the interview with MCP staff (G1). - HSH adhered to requirements for the member's authority, process and timing to file grievances and appeals. HSH's policies and procedures complied with these requirements. The interview session with HSH staff confirmed practices are in place (G2). - HSH complied with content requirements and timing of <i>Notices of Adverse Benefit Determination</i>. HSH's templates included all required criteria. HSH demonstrated adequate processes and internal monitoring to ensure notices are issued timely and when indicated. HSH's policies, procedures and monitoring data were reviewed to ensure compliance (G3).

Strengths
• HSH complied with requirements for handling grievances and appeals, including acknowledgement, local committee composition and requirements and special requirements for appeals. HSH demonstrated compliance through documentation submitted and the interview session with HSH staff (G4). • HSH complied with requirements for an expedited review process for appeals. HSH demonstrated compliance through documentation submitted, the interview session with HSH staff and the verification activity, which demonstrated appropriate resolution of expedited appeals (G6). • HSH provided information about the grievance and appeal system to providers and subcontractors. Documentation submitted and the interview with HSH staff confirmed practices are in place (G7). • HSH complied with record keeping requirements for grievances and appeals. Records submitted included all required criteria (G8). • HSH complied with requirements to reinstate benefits for reversed denials. Documentation submitted and the interview with HSH staff confirmed practices are in place (G10).

Table 53. HSH: Compliance Recommendations.

Recommendations Based on Weaknesses/Opportunities for Improvement
• Ensure a written acknowledgement of receipt for each grievance received is sent within the required timeframes (G4.2). • Ensure a written notice of resolution for each grievance is sent within the required timeframes (G5.1). • Revise documentation to include the requirement that benefits will be continued if the member appeal is filed timely (G9.1).

Show Me Healthy Kids

Table 54 and Table 55 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for SMHK.

Table 54. SMHK: Compliance Strengths.

Strengths
• SMHK had a grievance and appeal system in place that includes an internal grievance process, an appeal process and access to the state's Fair Hearing system. SMHK demonstrated compliance through documentation submitted and the interview with MCP staff (G1). • SMHK adhered to requirements for the member's authority, process and timing to file grievances and appeals. SMHK's policies and procedures complied with these requirements. The interview session with SMHK staff confirmed practices are in place (G2). • SMHK complied with content requirements and timing of <i>Notices of Adverse Benefit Determination</i>. SMHK's templates included all required criteria. SMHK's demonstrated adequate processes and internal monitoring to ensure notices are issued timely and when indicated. SMHK's policies, procedures and monitoring data were reviewed to ensure compliance (G3). • SMHK complied with requirements for handling grievances and appeals, including acknowledgement, local committee composition and requirements and special requirements

Strengths

for appeals. SMHK demonstrated compliance through documentation submitted and the interview session with SMHK staff **(G4)**.

- SMHK complied with requirements for an expedited review process for appeals. SMHK demonstrated compliance through documentation submitted, the interview session with SMHK staff and the verification activity, which demonstrated appropriate resolution of expedited appeals **(G6)**.
- SMHK provided information about the grievance and appeal system to providers and subcontractors. Documentation submitted and the interview with SMHK staff confirmed practices are in place **(G7)**.
- SMHK complied with record keeping requirements for grievances and appeals. Records submitted included all required criteria **(G8)**.
- SMHK complied with requirements to reinstate benefits for reversed denials. Documentation submitted and the interview with SMHK staff confirmed practices are in place **(G10)**.

Table 55. SMHK: Compliance Recommendations.**Recommendations Based on Weaknesses/Opportunities for Improvement**

- Ensure a written acknowledgement of receipt for each grievance received is sent within the required timeframes **(G4.2)**.
- Ensure a written notice of resolution for each grievance is sent within the required timeframes **(G5.1)**.
- Revise documentation to include the requirement that benefits will be continued if the member appeal is filed timely **(G9.1)**.

United Healthcare

Table 56 and Table 57 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for UHC.

Table 56. UHC: Compliance Strengths.**Strengths**

- UHC had a grievance and appeal system in place that includes an internal grievance process, an appeal process and access to the state's Fair Hearing system. UHC demonstrated compliance through documentation submitted and the interview with MCP staff **(G1)**.
- UHC adhered to requirements for the member's authority, process and timing to file grievances and appeals. The MCP's policies and procedures complied with these requirements. The interview session with UHC staff confirmed practices are in place **(G2)**.
- UHC complied with content requirements and timing of *Notices of Adverse Benefit Determination*. UHC's templates included all required criteria. The MCP demonstrated adequate processes and internal monitoring to ensure notices are issued timely and when indicated. UHC's policies, procedures and monitoring data were reviewed to ensure compliance **(G3)**.
- UHC complied with requirements for handling grievances and appeals, including acknowledgement, local committee composition and requirements and special requirements for appeals. UHC demonstrated compliance through documentation submitted, the interview session with UHC staff and a verification of a sample of UHC's local grievances and appeals filed in 2024. The verification activity demonstrated appropriate handling of grievances and

Strengths
appeals (G4). • UHC complied with requirements for an expedited review process for appeals. UHC demonstrated compliance through documentation submitted, the interview session with MCP staff and the verification activity, which demonstrated appropriate resolution of expedited appeals (G6). • UHC provided information about the grievance and appeal system to providers and subcontractors. Documentation submitted and the interview with UHC staff confirmed practices are in place (G7). • UHC complied with record keeping requirements for grievances and appeals. Records submitted included all required criteria (G8). • UHC complied with requirements for continuation of benefits while the local and state Fair Hearing are pending, the duration of continued or reinstated benefits and member responsibility for costs. Documentation submitted and the interview with UHC staff confirmed practices are in place (G9). • UHC complied with requirements to reinstate benefits for reversed denials. Documentation submitted and the interview with UHC staff confirmed practices are in place (G10).

Table 57. UHC: Compliance Recommendations.

Recommendations Based on Weaknesses/Opportunities for Improvement
• Ensure written notices of standard appeal resolution are sent no later than 30 calendar days past the filing date (G5.1).

Progress on Previous Year (2024) Plan Level Compliance EQRO Recommendations

Table 58 presents the plan level EQRO recommendations from the previous review, along with the degree to which plans have addressed the previous year's EQRO recommendations. The MCPs' efforts to address these recommendations were assessed through the RA process, formerly known as a corrective action plan, during the current review period and are summarized below. MCP-specific progress is provided in the individual [MCP 2025 Compliance with Standards reports](#).

Key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Table 58. Compliance Plan Level Progress on 2024 Recommendations.

MCP	Total Received	Met	Not Met	Degree to which plans addressed all EQRO recommendation(s)
HB	8	8	0	High
HSH	7	7	0	High
SMHK	8	8	0	High
UHC	7	7	0	High

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Network Adequacy Validation (NAV)

Objective

States are required to ensure that CHIPs and MCPs have provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across all services. Per §438.207, states must ensure that each MCP has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care. According to §438.68, states must establish measurable network adequacy standards for MCPs that consider regional factors and the needs of their Medicaid and CHIP populations. In addition, if the state enrolls American Indians and Alaska Natives in the MCP, it must comply with §438.14(b)(1). State-defined network adequacy standards must be included in the state's quality strategy per §438.340(b)(1).

Overview

The purpose of NAV is to assess how well the MCPs complied with network adequacy requirements over the past 12 months, as outlined in §438.68. This activity involves validating MCP performance against the state-defined criteria detailed in MO HealthNet's 2025 Provider Network Adequacy Standards. Please refer to Table 59 through Table 64 below for a list of the standards.



MHD developed the following time and travel distance standards that align managed care network adequacy reviews with federal requirements per §§438.68, 438.206, 438.207, 438.358(b)(1)(iv), 457.1218 and 457.1230. Comagine Health conducted validation of network adequacy according to the MHD defined network standards.



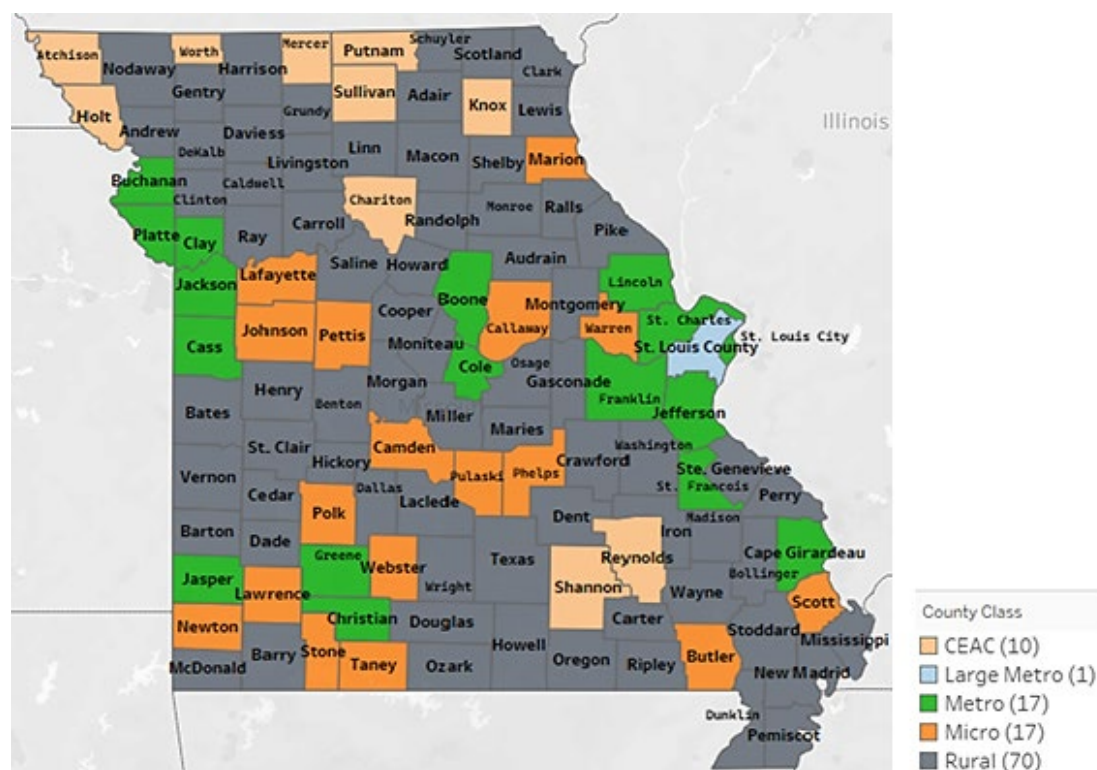
The MHD defined standard is for 100% of enrollees to have access to a provider within the applicable travel time or distance in all categories. Any score of 99.5% and above will be rounded up to 100%. Percent of access is determined by meeting either time or distance standards. Note: these standards fall under the domains of access and timeliness of health care and services.



Provider Network Adequacy Standards

Geographically, Missouri is made up of 115 counties, including St. Louis City. Based on population and density, approximately 70% of Missouri counties are classified as rural or counties with extreme access considerations (CEAC). Therefore, MHD has chosen to apply the county designations of large metro, metro, micro, rural and CEAC to each county as shown in Figure 18.

Figure 18. Map of County Designations.



MHD's 2025 network adequacy standards are outlined below by provider type and specialty for adult and pediatric services, including county type designations and classifications (Large Metro, Metro, Micro, Rural and CEAC). Pediatric standards apply to members enrolled in managed care ages 0 through 20 years old. Table 59 shows the network standards for Primary Care – Adult and Pediatric.

Table 59. NAV Provider Type: Primary Care – Adult and Pediatric.

Standard: 100% of MCP enrollees must have access to two providers within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Adult Primary Care Providers (PCPs)	15 miles or 20 minutes	30 miles or 45 minutes
Pediatric Primary Care Providers (PCPs)	15 miles or 20 minutes	30 miles or 45 minutes

Table 60 shows the network standards for Dental – Adult and Pediatric.

Table 60. NAV Provider Type: Dental – Adult and Pediatric.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Dental	25 miles or 40 minutes	40 miles or 55 minutes
Pediatric Dental	25 miles or 40 minutes	40 miles or 55 minutes

Table 61 shows the network standards for Ancillary and Facility provider types.

Table 61. NAV Provider Type: Facility and Ancillary Provider Types.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Hospital	30 miles or 45 minutes	40 miles or 55 minutes
Audiology	30 miles or 45 minutes	60 miles or 75 minutes
Occupational Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Physical Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Speech Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Inpatient Mental Health (MH)	40 miles or 55 minutes	75 miles or 90 minutes
Ambulatory MH	30 miles or 45 minutes	60 miles or 75 minutes

Table 62 shows the network standards for OB/GYN.

Table 62. NAV Provider Type: OB/GYN.

Standard: 100% of MCP enrollees must have access to two providers within specified time or distance standards.

Provider Type	Large Metro, Metro	Micro	Rural, CEAC
OB/GYN	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes

Table 63 shows the network standards for Behavioral Health – Adult and Pediatric.

Table 63. NAV Provider Type: Behavioral Health – Adult and Pediatric.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro	Metro	Micro	Rural	CEAC
Mental Health (MH)/ Substance Use Disorder (SUD) – Adult	10 miles or 15 minutes	20 miles or 30 minutes	30 miles or 45 minutes	40 miles or 55 minutes	50 miles or 65 minutes
Mental Health (MH)/ Substance Use Disorder (SUD) – Pediatric	10 miles or 15 minutes	20 miles or 30 minutes	30 miles or 45 minutes	40 miles or 55 minutes	50 miles or 65 minutes
Psychiatrist – Adult	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes	80 miles or 100 minutes	90 miles or 120 minutes
Psychiatrist – Child/Adolescent	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes	80 miles or 100 minutes	90 miles or 120 minutes

Table 64 shows the network standards for Specialists – Adult and Pediatric.

Table 64. NAV Provider Type: Specialists — Adult and Pediatric.*

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type**	Large Metro	Metro	Micro	Rural	CEAC
Adult and Pediatric Specialists (17 specialties)	25 miles or 40 minutes	50 miles or 65 minutes	75 miles or 90 minutes	90 miles or 120 minutes	110 miles or 145 minutes
Adult and Pediatric Specialists (4 specialties)	15 miles or 20 minutes	35 miles or 50 minutes	45 miles or 60 minutes	60 miles or 75 minutes	80 miles or 100 minutes

**Specialties in this table will be analyzed individually by medical professional code and separated by adult and pediatric populations.*

***See table 66 below for complete list of provider specialties.*

In addition to the network standards above, the MCPs must meet the following contract requirement:

- Per section 2.5.19 of the MCP contract – American Indian/Alaska Natives – The health plan shall ensure that American Indian/Alaska Natives are permitted to receive care from Indian Health Care Providers (IHCP) as defined in 42 CFR 438.14. The health plan must comply with the provisions of §§438.14 and 447.56.

Methodology

To ensure network adequacy, Comagine Health completed a comprehensive validation process for each MCP following the method outlined in *CMS Protocol 4. Validation of Network Adequacy* during the period of June – August 2025.

The validation of network adequacy is based on completing the protocol worksheets, particularly 4.6, which focuses on the Assessment of MCP Network Adequacy Data, Methods and Results. The MCP's membership, enrollment and provider information systems were reviewed as part of their HEDIS® Compliance Audits.¹⁵ Comagine Health reviewed the HEDIS compliance audit FARs for membership, enrollment and provider systems. The HEDIS compliance audit includes an overall assessment of the capability of the MCP's information systems to capture and process the information required for reporting data. See the [Information System Capabilities Assessment \(ISCA\)](#) section for additional information on the HEDIS audit and FARs.

Additionally, it includes validating network adequacy through file submissions from both the MCPs and MHD, along with reports produced by Quest Analytics. Quest Analytics' Quest Enterprise Services network adequacy analysis software was used to compile and analyze member enrollment and provider network information provided by MHD and the MCPs. Each quarter, MHD provides managed care enrollment files to Quest Analytics and the MCPs submit quarterly provider network files to MHD using specified file formats. The EQR review was based on the third submission of the provider network data files as of July 1, 2025, due the last working day of July 2025.

In addition, Comagine Health reviewed documentation provided by each MCP to confirm they met the requirements set forth in 42 CFR §438.68 and, if the state enrolls American Indians and Alaska Natives in the MCP, PIHP or PAHP, 42 CFR §438.14(b)(1). The review also evaluated each MCP provider network in relation to MHD's contractual requirements and 2024 Provider Network Adequacy Standards.

¹⁵ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Provider Network Access Results

Comagine Health completed a review of the data and methods used to calculate the provider network access indicator results and has high confidence in the provider network access indicator results. The tables below summarize each MCP's provider network access results, along with aggregate results (MO) at the program level, which include the percentage meeting access standards, categorized by provider type and county classification.

Summary of Plan Level Provider Network Access Indicator Results

Findings are scored by specialty and county classification. Please refer to the Provider Network Adequacy Standards section, above, for the distance/time standards. The MHD defined standard is for 100% of enrollees to have access to a provider within the applicable travel time or distance in all categories. They are categorized as "Met" if 99.5% or more of the network access indicators are achieved and "Not Met" if 99.4% or fewer are achieved.

MCPs are considered to have a comprehensive network if they meet 90% or greater of the network indicators. Overall, the network adequacy standards review and validation results for the MCPs and MO indicate a very comprehensive provider network.

Across HB, HSH/SMHK, and UHC, there are 290 applicable indicators each, totaling 870 indicators. HB met 273 indicators (94.1%), HSH/SMHK met 278 indicators (95.9%), and UHC achieved the highest performance by meeting 281 indicators (96.9%). Collectively, the three MCPs met 832 of the 870 indicators, resulting in an overall compliance rate of 95.6%. These results highlight strong performance across all plans.

Table 65 below shows the number and percentage of network adequacy indicators achieved by each MCP.

Table 65. Summary of Plan Level Provider Network Adequacy Indicators Results

MCP	Total # of indicators	Total # of indicators met	Total # of indicators not met	% Met
HB	290	273	17	94.1%
HSH/SMHK	290	278	12	95.9%
UHC	290	281	9	96.9%
MO Total	870	832	38	95.6%

Table 66 below shows the percentage of network access results for each network adequacy indicator by provider type and county classification for the MCPs as well as an aggregate result (MO) at the program level. The indicators not met are highlighted in orange in the table.

Table 66. Provider Network Access Indicator Result by MCP and County Designation.

	HB					HSH/SMHK					UHC				
Provider Type	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC
Primary Care															
Adult Primary Care Providers	100%	100%	99.9%	100%	100%	100%	99.9%	99.8%	100%	100%	100%	100%	99.9%	100%	100%
Pediatric Primary Care Providers	100%	100%	100%	100%	100%	100%	99.9%	99.9%	100%	100%	100%	100%	99.9%	100%	100%
Dental															
Adult Dental	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pediatric Dental	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.9%	100%	100%	100%	100%	99.9%
Facility															
Hospital	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ancillary															
Audiology	100%	97.5%	93.2%	100%	94.2%	100%	99.9%	100%	99.8%	97.9%	100%	98.2%	90.8%	99.7%	100%
Occupational Therapy	100%	100%	92.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physical Therapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.0%
Speech Therapy	100%	100%	100%	100%	98.6%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93.6%
Mental Health															
Inpatient Mental Health	100%	98.6%	97.9%	99.8%	90.4%	100%	100%	100%	100%	95.9%	100%	100%	100%	100%	100%
Ambulatory Mental Health	100%	100%	91.7%	94.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OB/GYN															
OB/GYN	100%	99.9%	100%	100%	100%	100%	99.7%	100%	100%	100%	100%	100%	100%	100%	100%
Behavioral Health - Adult and Pediatric															
Mental Health and SUD - Adult	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mental Health and SUD - Pediatric	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatrist															
Psychiatrist - Adult	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatrist – Child/Adolescent	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	HB					HSH/SMHK					UHC				
Provider Type	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC
Specialists - Adult															
Allergy	100%	100%	99.4%	95.7%	100%	100%	98.6%	92.1%	94.6%	100%	100%	97.3%	94.7%	99.4%	100%
Cardiology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Chiropractic	100%	100%	100%	99.5%	100%	100%	100%	98.4%	97.0%	100%	100%	100%	100%	99.9%	100%
Dermatology	100%	99.0%	100%	100%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%	100%	100%
Endocrinology	100%	100%	99.9%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastroenterology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
General Surgery	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hematology/ Oncology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Infectious Disease	100%	99.7%	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Orthopedics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pediatrics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physical Medicine/ Rehab	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.8%	100%	100%
Podiatry	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Primary Eye Care/ Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pulmonary Disease	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Rheumatology	100%	97.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Vision	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Specialists - Pediatric															
Allergy	100%	100%	100%	95.6%	100%	100%	98.8%	91.8%	94.6%	100%	100%	97.0%	94.4%	99.5%	100%
Cardiology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Chiropractic	100%	100%	100%	99.5%	100%	100%	100%	98.6%	96.8%	100%	100%	100%	100%	99.8%	100%
Dermatology	100%	99.1%	100%	100%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%	100%	100%
Endocrinology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastro-enterology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	HB					HSH/SMHK					UHC				
Provider Type	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC	Large Metro	Metro	Micro	Rural	CEAC
General Surgery	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hematology/ Oncology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Infectious Disease	100%	99.8%	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Orthopedics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pediatrics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physical Medicine/ Rehab	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.9%	100%	100%
Podiatry	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Primary Eye Care/ Ophthalmology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pulmonary Disease	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Rheumatology	100%	97.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Vision	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Summary of Program Level and Plan Level NAV Scores and Ratings

All MCPs must ensure that American Indian/Alaska Native members have the option to receive care from IHCPs, as required by MHD contract section 2.5.19 and defined in 42 CFR §438.14. Additionally, MCPs are required to comply with all provisions outlined in §§438.14 and 447.56. All MCPs met these requirements, ensuring compliance across all plans.

Comagine Health utilized the worksheets from *Protocol 4. Validation of Network Adequacy*, to support the review of the MCP's network adequacy. Worksheet 4.6 below was completed to evaluate and assess the data and methods used to calculate results generated for the network adequacy indicators. In addition, these worksheets supported the generation of a validation rating reflecting the overall adequacy.

The worksheet supported the generation of a validation rating that reflects the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

To support this review, Comagine Health collected supplemental information from each MCP, using the *MCP Network Adequacy Validation Submission Form*, to document their efforts to ensure the accuracy and completeness of submitted data.

Each element in the tables below is presented as either “Yes”, “No” or Not Applicable (NA)” based on the validation results. Elements scored “NA” are not included in the final scoring. Standard scores are presented as the number of “Yes” elements out of the total number of scoring elements.

Table 67 summarizes the overall assessment of the MCPs' data, methodology and results, while Table 68 summarizes the overall assessment of the MCPs' IS and results.

Table 67. Assessment of MCP Network Adequacy Data, Methods and Results.

Question	HB	HSH/ SMHK	UHC
Assessment of data collection procedures			
Did the MCP submit all required data sources and correct years of data for calculating each indicator (i.e., patterns of missing data that may affect the calculation of each indicator)?	Y	Y	Y
Did each data file, submitted by the MCP, include all needed variables, as specified in the File Specifications (provider, facility and ancillary) sections in the Provider Network Adequacy Standards document, for calculating each indicator?	Y	Y	Y
Do the MCP's data support valid, reliable and timely calculations of each indicator?	Y	Y	Y
Did the MCP's data collection tools and systems allow for consistent and accurate data collection for each indicator?	Y	Y	Y
Assessment of MCP Network Adequacy Methods			
Are the methods utilized by the MCP adequate to generate the data needed to calculate this indicator?	Y	Y	Y
Did the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist as indicated in the Provider Network Adequacy Standards document?	Y	Y	Y

Question	HB	HSH/ SMHK	UHC
Assessment of MCP network adequacy results			
Did the MCP avoid system and/or filtering issues that could have impacted the data submitted for calculating the network indicators?	Y	Y	Y
Did the MCP avoid system and/or filtering issues that remained unresolved for more than one quarter that could have impacted the data submitted for calculating the network indicators?	Y	Y	Y
Did the MCP meet 99.5% or greater provider adequacy during the report year?	Y	Y	Y
Did the MCP avoid and/or address recurring errors that contributed to provider inadequacies in quarterly reports throughout the reporting year?	Y	Y	Y
Did the MCP resolve all self-identified inadequacies before the end of the reporting quarter in which they were identified? These are plan identified inadequacies. (Enter NA if the MCP did not experience self-identified inadequacies before the end of the reporting quarter in which they were identified.)	Y	Y	Y
Did the MCP avoid prolonged inadequacies for any provider types for two or more consecutive quarters? (Enter NA if the MCP did not experience provider inadequacies.)	N	N	N
Did the MCP address inadequacies promptly and provide a timeline for closing coverage gaps? (Enter NA if the MCP did not experience provider inadequacies.)	Y	Y	Y
Was the MCP responsive to MHD's inquiries (email requests, Notices, CAPs, etc.) regarding provider network reporting activities? (Enter NA if MHD did not have any inquiries for the MCP.)	Y	Y	Y
Did the MCP fully meet section 2.5 Health Plan Provider Networks Requirements in the MCP contract? If no, provide details.	Y	Y	Y

Table 68. Assessment of MCPs' IS and results.

ISCA/FAR Results			
During the time period included in the reporting cycle, have there been any improvements or enhancements to the MCP's data systems that support the accuracy or completeness of network adequacy data used to calculate each indicator (e.g., major upgrades, system integrations or acquisitions/mergers that strengthened data capabilities)? If no improvements or enhancements were made, is it because the existing systems continue to function effectively and did not require any changes?	Y	Y	Y
Did the MCP receive zero findings in their HEDIS Compliance FARs that could have impacted network indicator reporting results?	Y	Y	Y
Did the MCP avoid any "yes" responses in worksheet 4.4 (column J) indicating no concerns impacted network indicator reporting results?	Y	Y	Y

NAV Scores and Ratings

The validation rating reflects the overall confidence that acceptable methodology was used during all phases of design, data collection, analysis and interpretation of the network adequacy indicators.

Table 69 and Table 70 provide the validation rating legend and an aggregate summary of the validation scores and ratings for all network adequacy indicators by MCP, including an aggregate overview (MO) result at the program level. All MCPs and MO received a validation score of 94.4% and validation rating of “High Confidence” for all provider network indicators.

Table 69. NAV Validation Rating Legend.

Validation Score	Validation Rating
≥ 90%	High confidence
50% – 89.9%	Moderate confidence
10% – 49.9%	Low confidence
≤ 9.9%	No confidence

Table 70. NAV MCP Score and Validation Rating.

Plan	Network Adequacy Indicators	# of Scoring Elements	% Score	Validation Rating
HB	All Provider Network Adequacy Indicators	17/18	94.4%	High confidence
HSH/SMHK	All Provider Network Adequacy Indicators	17/18	94.4%	High confidence
UHC	All Provider Network Adequacy Indicators	17/18	94.4%	High confidence
MO	Overall Provider Network Adequacy Indicators	51/54	94.4%	High confidence

Program Level NAV EQRO Recommendations

Based on program-level findings from the NAV review, the following recommendations are provided to MHD. Overall, the review and validation of network adequacy standards for the MO program level indicate that the MCPs maintain a comprehensive provider network. Overall, the MO program satisfied 832 out of 870 indicators for a result of 95.6% of the network adequacy standards being met.

After completing the Protocol 4 worksheets to assess MCP network adequacy, Comagine Health has high confidence in the data and methods used to calculate provider network access indicator results. No recommendations were identified to improve the reliability or validity of the data, processes or systems used by either the MCPs or MHD to monitor network adequacy, including those related to data systems, methodologies or staffing.

For the provider types and specialties where the MCPs did not meet the time or distance standard, MHD should work with the MCPs to assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs or other contributing factors. MHD should offer technical assistance to MCPs whenever specific needs are identified.

An update of the current year’s EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

Progress on Previous Year (2024) Program Level NAV EQRO Recommendations

Table 71 presents the EQRO recommendations from the previous review alongside the actions implemented by MHD.

Table 71. NAV Program Level Progress on Previous Recommendations.

EQRO Recommendation
For the provider types and specialties where the MCPs did not meet the time or distance standard, MHD should work with the MCPs to assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs or other contributing factors.
MCP Actions Taken
MHD is evaluating time/distance shortfalls and comparing network availability with provider enrollment and market dynamics. Additional strategies include transparency dashboards and telehealth integration. Collaboration with the Quest vendor has also supported a further understanding of network accessibility.
EQRO Response
The EQRO acknowledges MHD's work in addressing the recommendation. The response is accepted

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Summary of Plan Level NAV Findings and Recommendations

Table 72, Table 73 and Table 74 provide an overview of each MCP's findings, including strengths, opportunities for improvement and recommendations. MCPs are considered to have a comprehensive network if they meet 90% or greater of the network indicators. For more detailed information on the findings, please refer to the individual [MCP 2025 EQR NAV reports](#).

An update of the current year's EQRO recommendations will be reflected in the *2026 EQR Annual Technical Report*.

Table 72. HB NAV Findings and Recommendations.

Strengths
Overall, the network adequacy standards review and validation results for HB indicate that it has a comprehensive provider network. HB met 273 out of 290 (94.1%) of the network indicators.
Weaknesses/Opportunities for Improvement
HB did not meet the network access indicators and standards for the following provider types and counties:
- Audiology in the metro (97.5%), micro (93.2%) and CEAC (94.2%) county classifications - Occupational Therapy in the micro county classification (92.5%) - Speech Therapy in the CEAC county classification (98.6%) - Inpatient Mental Health in the metro (98.6%), micro (97.9%) and CEAC (90.4%) county classifications - Ambulatory Mental Health in the micro (91.7%) and rural (94.3%) county classifications - Adult Allergy in the micro (99.4%) and rural (95.7%) county classifications

- Adult Dermatology in the metro county classification **(99.0%)**
- Adult Rheumatology in the metro county classification **(97.7%)**
- Pediatric Allergy in the rural county classification **(95.6%)**
- Pediatric Dermatology in the metro county classification **(99.1%)**
- Pediatric Rheumatology in the metro county classification **(97.8%)**

Recommendations

For the provider types and counties where HB did not meet the time or distance standard, HB should evaluate whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCP or other contributing factors. HB is encouraged to collaborate with MHD to explore potential solutions for contracting with providers in the geographic areas where they did not meet the network standards.

Table 73. HSH/SMHK NAV Findings and Recommendations.

Strengths

Overall, the network adequacy standards review and validation results for HSH/SMHK indicate that it has a comprehensive provider network. HSH/SMHK met 278 out of 290 **(95.9%)** of the network indicators.

Weaknesses/Opportunities for Improvement

HSH/SMHK did not meet the network access indicators and standards for the following provider types and counties:

- Audiology in the CEAC county classification **(97.9%)**
- Inpatient Mental Health in the CEAC county classification **(95.9%)**
- Adult Allergy in the metro **(98.6%)**, micro **(92.1%)** and rural **(94.6%)** county classifications
- Adult Chiropractic in the micro **(98.4%)** and rural **(97.0%)** county classifications
- Pediatric Allergy in the metro **(98.8%)**, micro **(91.8%)** and rural **(94.6%)** county classifications
- Pediatric Chiropractic in the micro **(98.6%)** and rural **(96.8%)** county classifications

Recommendations

For the provider types and counties where HSH/SMHK did not meet the time or distance standard, MCP should evaluate whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCP or other contributing factors. HSH/SMHK is encouraged to collaborate with MHD to explore potential solutions for contracting with providers in the geographic areas where they did not meet the network standards.

Table 74. UHC NAV Findings and Recommendations.

Strengths

Overall, the network adequacy standards review and validation results for UHC indicate that it has a comprehensive provider network. UHC met 281 out of 290 **(96.9%)** of the network indicators.

Weaknesses/Opportunities for Improvement

UHC did not meet the network access indicators and standards for the following provider types and counties:

- Audiology in the metro **(98.2%)** and micro **(90.8%)** county classifications
- Physical Therapy in the CEAC county classification **(99.0%)**

- Speech Therapy in the CEAC county classification (**93.6%**)
- Adult Allergy in the metro (**97.3%**), micro (**94.7%**) and rural (**99.4%**) county classifications
- Pediatric Allergy in the metro (**97.0%**) and micro (**94.4%**) county classifications

Recommendations

For the provider types and counties where UHC did not meet the time or distance standard, UHC should evaluate whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCP or other contributing factors. UHC is encouraged to collaborate with MHD to explore potential solutions for contracting with providers in the geographic areas where they did not meet the network standards.

Progress on Previous Year (2024) Plan Level NAV EQRO Recommendations

Table 75 presents the plan level EQRO recommendations from the previous review, along with the degree to which plans have addressed the previous year's EQRO recommendations. MCP-specific progress is provided in the individual [MCP 2025 NAV reports](#).

Key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Table 75. NAV Plan Level Progress on 2024 Recommendations – Count and Degree Assessed.

MCP	Total Received	Met	Not Met	Degree to which plans addressed all EQRO recommendation(s)
HB	1	1	0	High
HSH/ SMHK	1	1	0	High
UHC	1	1	0	High

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Information System Capabilities Assessment (ISCA)

Objective

Per 42 CFR §§438.242 and 457.1233(d), MCPs are required to develop and maintain health information systems that reliably support essential operational activities and ensure full compliance with federal reporting standards and oversight responsibilities.

Overview



The ISCA outlines the essential functions and recommended standards for an MCP's information system, ensuring it meets federal and state regulatory requirements for quality assessment and performance reporting. It also establishes a structured methodology for the EQRO to evaluate the robustness, reliability and effectiveness of each MCP's data systems in supporting managed care oversight and accountability.

According to §438.360, states have the option to utilize results from a private accreditation review to avoid duplication of the required assessment of an MCP's information system. This substitution is permitted if the accreditation standards are comparable to those outlined in the EQR protocols and §438.358. To meet this requirement, information gathered during the HEDIS audit and presented in the FAR was reviewed by Comagine Health.

This technical report includes evaluations of the mandatory review activities — Compliance, NAV, PIP and PMV — which incorporate HEDIS audit findings from the FARs. It also includes additional assessments of MCP information systems, as needed, to support these activities.

- **Compliance** – During the appropriate Compliance review, Comagine Health evaluates each MCP's health information system to ensure it supports key operations and meets federal reporting requirements.
- **NAV** – During the NAV review, both the data sources and each MCP's systems for monitoring network adequacy were assessed. The review determined whether the systems could collect and report accurate data for each indicator.
- **PIPs** – If a PIP uses HEDIS measures, separate verification of data or performance results is unnecessary, as these measures have already been validated through the HEDIS audit process to ensure accuracy and reliability.
- **PMV** – Validated HEDIS measures define standard measures that MCPs must include in their QAPI programs. The HEDIS audit confirms these measures meet established requirements. It also ensures they are reportable, providing consistent and accurate data for monitoring, comparison and quality improvement.

Methodology – MY2024 HEDIS Audit

HEDIS audit findings are included in the FAR issued by an NCQA-licensed audit organization. These findings can help identify performance gaps and establish realistic targets for improvement, while confirming the MCP is meeting NCQA standards.¹⁶

¹⁶ <https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/about-the-hedis-compliance-audit/>

To support its EQR activities, Comagine Health reviewed the FARs to determine and develop EQR findings and recommendations. These results offer an independent evaluation of the MCP's performance measurement and data reporting processes, assessing the accuracy and reliability of the performance measure data submitted to NCQA.

Scoring

Comagine Health assigns a score of "Met," "Not Met" or "Not Applicable (NA)" based on the MCP FAR results. FAR standard results labeled as "Met" or "Partially Met (No Impact Identified)" are treated as meeting the standard by Comagine Health, while all other outcomes are considered not met.

The overall ISCA score is presented as the number of "Met" elements out of the total number of scoring elements possible. Scores below 90% are viewed as weaknesses or opportunities for improvement and are considered not met.

Summary of MCP MY2024 HEDIS FAR Results

Table 76 shows the MCP FAR results for each standard addressed for MY2024.

Table 76. Summary of MCP MY2024 IS HEDIS FAR Results.

IS R: Data Management and Reporting (formerly IS 6.0, 7.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
R1	The organization's data management enables measurement.	Met	Met	Met
R2	Data extraction and loads are complete and accurate.	Met	Met	Met
R3	Data transformation and integration is accurate and valid.	Met	Met	Met
R4	Data quality and governance are components of the organization's data management.	Met	Met	Met
R5	Oversight and controls ensure correct implementation of measure reporting software.	Met	Met	Met
R6	Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	Met	Met	Met
IS C: Clinical and Care Delivery Data (formerly IS 5.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
C1	Data capture is complete.	Met	Met	Met
C2	Data conform with industry standards.	Met	Met	Met
C3	Transaction file data are accurate.	Met	Met	Met
C4	Organization ingested data meet expectations for data quality.	Met	Met	Met
IS M: Medical Record Review Processes (formerly IS 4.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
M1	Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).	Met	Met	Met
M2	Retrieval and abstraction of data from medical records is reliably and accurately performed.	Met	Met	Met

M3	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.	Met	Met	Met
M4	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
M5	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS A: Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)				
Std.	Information System Description	HB	HSH/SMHK	UHC
A1	Data conform with industry standards and measure requirements.	Met	Met	Met
A2	Data are complete and accurate.	Met	Met	Met
A3	Membership information system enables measurement.	Met	Met	Met
HD 4.0 Algorithmic Compliance				
Std.	Information System Description	HB	HSH/SMHK	UHC
HD 4.1	Summary-level calculations are arithmetically correct and precise.	Met	Met	Met
HD 4.2	Algorithm for combining numerator events when data are coming from multiple data sources are accurate.	Met	Met	Met
HD 5.0 Outsourced or Delegated Reporting Functions				
Std.	Information System Description	HB	HSH/SMHK	UHC
HD 5.1	If the organization delegates any aspect of measure data collection or reporting to an external software vendor, software vendor data meet all applicable NCQA HEDIS Compliance Audit standards.	Met	Met	Met
HD 5.2	The organization regularly monitors software vendor performance against expected performance standards.	Met	Met	Met
HD 5.3	If aspects of measure data collection or reporting are delegated to multiple software vendors, the organization coordinates software vendor activities to safeguard the integrity of measure data.	Met	Met	Met
HD 5.4	The organization works with the vendor to get preliminary and final rates according to the audit timeline.	Met	Met	Met

Summary of the Individual MCP ISCA Results

Table 77 presents the overall ISCA scores assigned to the MCPs for MY2024.

Table 77. MY2024 ISCA Results.

MCP	Scoring Elements	% Score	Overall Score
HB	24/24	100%	Met
HSH/SMHK	24/24	100%	Met
UHC	24/24	100%	Met

Results: The MCPs met all standards of the ISCA. No EQRO recommendations, strengths or weaknesses were noted.

Progress on Previous Year (2024) EQRO ISCA Recommendations

Comagine Health did not perform an ISCA during the CY2024 EQR. Therefore, the CY2025 ISCA activity did not include a review of recommendations.

Summary of MCP MY2022 - MY2023 HEDIS FAR Results

Per CMS direction, Comagine Health is reporting the MY2022 and MY2023 HEDIS FAR results in this report. Please note that the IS standards have evolved over the reporting cycle.

MY2023 HEDIS FAR Results

Table 78 shows the MCP FAR results for each standard addressed for MY2023.

Table 78. Summary of MCP MY2023 IS HEDIS FAR Results.

IS R: Data Management and Reporting (formerly IS 6.0, 7.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
R1	The organization's data management enables measurement.	Met	Met	Met
R2	Data extraction and loads are complete and accurate.	Met	Met	Met
R3	Data transformation and integration is accurate and valid	Met	Met	Met
R4	Data quality and governance are components of the organization's data management.	Met	Met	Met
R5	Oversight and controls ensure correct implementation of measure reporting software.	Met	Met	Met
IS C: Clinical and Care Delivery Data (formerly IS 5.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
C1	Data capture is complete.	Met	Met	Met
C2	Data conform with industry standards.	Met	Met	Met
C3	Transaction file data are accurate.	Met	Met	Met
C4	Organization ingested data meet expectations for data quality.	Met	Met	Met
IS M: Medical Record Review Processes (formerly IS 4.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
M1	Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).	Met	Met	Met
M2	Retrieval and abstraction of data from medical records is reliably and accurately performed.	Met	Met	Met
M3	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.	Met	Met	Met
M4	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
M5	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met

IS A: Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)				
Std.	Information System Description	HB	HSH/ SMHK	UHC
A1	Data conform with industry standards and measure requirements.	Met	Met	Met
A2	Data are complete and accurate.	Met	Met	Met
A3	Membership information system enables measurement.	Met	Met	Met

Results: The MCPs met all standards of the MY2023 HEDIS audit. No EQRO recommendations, strengths or weaknesses were noted.

Follow Up on Previous Year: In MY2023, HSH/SMHK addressed to a high degree the following IS HEDIS FAR standards where it did not meet all requirements for the MY2022 HEDIS audit:

- 5.2 – The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.
- 5.5 – The organization regularly monitors vendor performance against expected performance standards.

MY2022 HEDIS FAR Results

Table 79 shows the MCP FAR results for each standard addressed for MY2022.

Table 79. Summary of MCP MY2022 IS HEDIS FAR Results.

IS 1.0: Medical Services Data—Sound Coding Methods, Data Capture, Transfer and Entry				
Std.	Information System Description	HB	HSH/ SMHK	UHC
1.1	Industry standard codes are used and all characters are captured.	Met	Met	Met
1.2	Principal codes are identified, and secondary codes are captured.	Met	Met	Met
1.3	Nonstandard coding schemes are fully documented and mapped back to industry standard codes.	Met	Met	Met
1.4	Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.	Met	Met	Met
1.5	Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for measure reporting.	Met	Met	Met
1.6	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
1.7	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS 2.0: Enrollment Data—Data capture, Transfer and Entry				
Std.	Information System Description	HB	HSH/ SMHK	UHC
2.1	The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.	Met	Met	Met
2.2	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.	Met	Met	Met

2.3	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
2.4	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS 3.0: Practitioner Data—Data Capture, Transfer and Entry				
Std.	Information System Description	HB	HSH/ SMHK	UHC
3.1	Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting.	Met	Met	Met
3.2	The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.	Met	Met	Met
3.3	Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.	Met	Met	Met
3.4	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
3.5	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS 4.0: Medical Record Review Processes—Sampling, Abstraction and Oversight				
Std.	Information System Description	HB	HSH/ SMHK	UHC
4.1	Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).	Met	Met	Met
4.2	Retrieval and abstraction of data from medical records is reliably and accurately performed.	Met	Met	Met
4.3	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.	Met	Met	Met
4.4	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
4.5	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS 5.0: Supplemental Data—Capture, Transfer and Entry				
Std.	Information System Description	HB	HSH/ SMHK	UHC
5.1	Nonstandard coding schemes are fully documented and mapped to industry standard codes.	Met	Met	Met
5.2	The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.	Met	Partially Met	Met
5.3	Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.	Met	Met	Met
5.4	The organization continually assesses data completeness and takes steps to improve performance.	Met	Met	Met
5.5	The organization regularly monitors vendor performance against expected performance standards.	Met	Partially Met	Met

5.6	Data approved for ECDS reporting met reporting requirements.	Met	Met	Met
5.7	NCQA-validated data resulting from the Data Aggregator Validation program met reporting requirements.	Met	Met	Met
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity				
Std.	Information System Description	HB	HSH/SMHK	UHC
6.1	Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.	Met	Met	Met
6.2	Data transfers to HEDIS repository from transaction files are accurate.	Met	Met	Met
6.3	File consolidations, extracts and derivations are accurate.	Met	Met	Met
6.4	Repository structure and formatting are suitable for measures and enable required programming efforts.	Met	Met	Met
6.5	Repository structure and formatting are suitable for measures and enable required programming efforts.	Met	Partially Met	Met
6.6	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
7.0 Data Integrity and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity				
Std.	Information System Description	HB	HSH/SMHK	UHC
7.1	Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.	Met	Met	Met
7.2	Report production is managed effectively, and operators perform appropriately.	Met	Met	Met
7.3	Measure reporting software is managed properly regarding development, methodology, documentation, version control and testing.	Met	Met	Met
7.4	The organization regularly monitors vendor performance against expected performance standards.	Met	Met	Met
IS 8.0 Case Management Data—Long Term Services and Support (LTSS) Audits				
Std.	Information System Description	HB	HSH/SMHK	UHC
8.1	Participant eligibility data have necessary procedures to ensure accuracy.	Met	NA	NA
8.2	Case Management submission forms/tools capture all fields relevant to LTSS reporting.	Met	NA	NA
8.3	Case Management intervention tools capture all data relevant to LTSS reporting.	Met	NA	NA
8.4	Data transfers to LTSS repository are accurate and repository structure and formatting are suitable for LTSS measure production.	Met	NA	NA

Results: HB and UHC met all standards of the MY2022 HEDIS audit. However, HSH/SMHK partially met two standards but were found to have no impact upon intended HEDIS measure rates. No EQRO recommendations, strengths or weaknesses were noted.

Follow Up on Previous Year: MHD contracted with Comagine Health as the EQRO, effective Jan. 1, 2024. Since the contract took effect after the MY2021 reporting period, Comagine Health was not involved in the review of the MY2021 HEDIS FARs and progress was not assessed for MY2021.

Care Management (CM) Review

Objective

According to §438.358 (c)(5), states may direct their EQROs to conduct focus studies for quality improvement, administrative, legislative or other purposes. Focus studies assess a particular aspect of clinical or nonclinical services at a point in time.

The purpose of this focus study is to identify contributing factors and key drivers, including any challenges within the MCP's CM programs. To ensure an MCP is in compliance with CM requirements in its contract with MHD, MetaStar, under contract with Comagine Health, completed a comprehensive review of documents and clinical records provided by the MCPs. The information gathered during the review helps assess the quality, access and timeliness of care provided to Medicaid beneficiaries within its CM program.

Overview

The review consisted of two components to assess compliance with CM requirements in its contract with MHD (Amendment 3):



1. **Compliance with Contractual Requirements (referred to in this report as document review)** – an assessment of MCP's compliance with CM contractual requirements, utilizing documentation submitted for selected criteria to be reviewed.
2. **Clinical Records Review (referred to in this report as clinical review)** – an assessment of MCP's compliance with CM contractual requirements, utilizing a review of clinical records submitted for selected criteria to be reviewed.

Methodology

The review followed the guidelines from CMS, *EQR Protocol 9. Conducting Focus Studies of Health Care Quality*. This protocol provides a structured framework for a particular aspect of clinical care or nonclinical services provided by an MCP at a point in time. The document review and clinical record review were conducted using review tools and reviewer guidelines developed by MetaStar and approved by MHD. The review included the focus areas below:

- **Focus Area 1:** Multiple Comorbid Conditions
- **Focus Area 2:** Pregnancy/Obstetrics
- **Focus Area 3:** Individuals in Foster Care, Receiving Foster Care or an Adoption Subsidy or Other Out-of-Home Placement, referred to in this report as Foster Care (**SMHK Only**)

The review assessed criteria for each focus area against contract requirements in effect from Jan. 1, 2024 through Dec. 31, 2024 (referred to as CY2025 in this report). The evaluation focused on the following areas of CM practice:

- **Enrollment and Assessment (EA)**
- **Care Planning (CP)**
- **Care Coordination (CC)**
- **CM Closure (CL)¹⁷**

¹⁷ Closure (CL) is not applicable to Focus Area 3.

For each focus area, the document review examined the MCP's applicable policies and procedures to determine alignment with contractual requirements. In addition, the clinical record review evaluated whether the corresponding practices were effectively implemented.

The document review includes a specified number of scoring elements for each CM practice area that are based on the contract requirements for the focus area. The number of scoring elements will vary depending on the focus area. Table 80, Table 81 and Table 82 below identify the area of practice and document review requirements for each focus area.

Table 80. CM Document Review Focus Area 1: Multiple Comorbid Conditions.

Practice Area	Citations	Scoring Elements
EA	CM Record Documentation – 2.12.1(c); and General Eligibility and Assessment for CM – 2.12.1(e)(2),(4)	4
CP	Principles of Member CM – 2.12.1(a)(2),(3); and CM Record Documentation – 2.12.1(c)(12),(13)	3
CC	CM Record Documentation – 2.12.1(c)(2),(14-22); and General Eligibility and Assessment for CM – 2.12.1(e)(4)	2
CL	CM Closure – 2.12.1(g)	1

Table 81. CM Document Review Focus Area 2: Pregnancy/Obstetrics.

Practice Area	Citations	Scoring Elements
EA	CM Record Documentation – 2.12.1(c); and General Eligibility and Assessment for CM – 2.12.1(e)(2),(4)	4
CP	Principles of Member CM – 2.12.1(a)(2),(3); and CM Record Documentation – 2.12.1(c)(12),(13)	3
CC	CM Record Documentation – 2.12.1(c)(2),(14-22); and General Eligibility and Assessment for CM – 2.12.1(e)(4)(6)	2
CL	CM Closure – 2.12.1(g)	1

Table 82. CM Document Review Focus Area 3: Foster Care.

Practice Area	Citations	Scoring Elements
EA	CM Record Documentation – 2.12.1(c); Principles of CM – 3.9.3(a); and CM Assignment 3.9.8(a-g)	3
CP	Principles of Member CM – 2.12.1(a)(2); Principles of CM – 3.9.3; and CM Policy Requirements – 3.9.15(a)	3
CC	CM Record Documentation – 2.12.1(c)(14-22); CM Program Plan – 3.9.4(e); CM Coordination and Accountability – 3.9.9; CM Activities – 3.9.10(a-m); and Member Transition of Care – 3.9.16	2

The clinical review includes requirements for each CM practice and were grouped into indicators for each focus area. The number of indicators will vary depending on the focus area.

Table 83, Table 84 and Table 85 below identify the area of practice and clinical review indicator for each focus area.

Table 83. CM Clinical Review Focus Area 1: Multiple Comorbid Conditions.

Practice Area	Indicator	Indicator Description
EA	Indicator 1	Assessment (or other documentation in the record) was comprehensive
EA	Indicator 2	Assessments occurred timely
CP	Indicator 3	Care plan was comprehensive
CP	Indicator 4	Required care planning processes were evidenced
CP	Indicator 5	Care plan was updated timely
CC	Indicator 6	Evidence of coordination and follow-up are documented in the record
CC	Indicator 7	Appropriate referrals are documented in the record
CL	Indicator 8	The CM closure requirements were satisfied
EA	Indicator 9	Disease management (DM) was offered timely
EA	Indicator 10	The “opt out” methodology for DM was utilized

Table 84. CM Clinical Review Focus Area 2: Pregnancy/Obstetrics.

Practice Area	Indicator	Indicator Description
EA	Indicator 1	Assessment (or other documentation in the record) was comprehensive
EA	Indicator 2	Assessments occurred timely
EA	Indicator 3	CM was offered timely to pregnant members
CP	Indicator 4	Care plan was comprehensive
CP	Indicator 5	Required care planning processes were evidenced
CP	Indicator 6	Care plan was updated timely
CC	Indicator 7	Evidence of coordination and follow-up are documented in the record
CC	Indicator 8	Timely follow-up for post-partum medical appointments
CC	Indicator 9	Appropriate assistance is provided to pregnant members
CC	Indicator 10	Appropriate referrals are documented in the record
CL	Indicator 11	The CM closure requirements were satisfied

Table 85. CM Clinical Review Focus Area 3: Foster Care (SMHK Only).

Practice Area	Indicator	Indicator Description
EA	Indicator 1	Assessment (or other documentation in the record) was comprehensive
EA	Indicator 2	Assessments occurred timely
EA	Indicator 3	Specialty plan member's tier assignment is re-evaluated as required
CP	Indicator 4	Care plan was comprehensive
CP	Indicator 5	Required care planning processes were evidenced
CP	Indicator 6	Care plan was updated timely
CC	Indicator 7	Evidence of coordination and follow-up are documented in the record
CC	Indicator 8	Appropriate referrals are documented in the record

See [Appendix E: CM Review Methodology](#) for more information on the focus area and review criteria.
for more information on the focus area and review criteria.

Summary of Program and Plan Level CM Review Results



The document review evaluates the MCPs' CM policies and procedures for the previous calendar year (Jan. 1, 2024 through Dec. 31, 2024), while the clinical review verifies that these practices were carried out during the same timeframe.



Random samples of clinical records were selected for each focus area and assessed against the applicable contract requirements in effect during the review period.

Each CM practice area will receive a compliance rating for the document review and the corresponding clinical review indicators. Each CM practice area has a specified number of scoring elements for the document review and indicators for the clinical review, which vary by focus area.

The clinical review rate for CY2025 is compared to both the Medicaid Statewide Rate (MSR)¹⁸ for the same year and the MCPs' rate from CY2024.¹⁹ Statistically significant changes between CY2024 and CY2025 are also highlighted.

Additionally, the document review table includes the overall rate reported at the program level (MSR). Results for the document review are not comparable to the prior review due to revisions in the document review criteria.

In order to determine the significance of year-to-year results, a Pearson's chi-squared test was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the MCP or whether changes were due to normal variation.²⁰

Scoring

Findings are scored by focus area and categorized as "Strength," "Compliant" and "Opportunity for Improvement," with their corresponding compliance rating in the scoring legend below.²¹ Recommendations are provided for all identified weaknesses and opportunities for improvement, followed by the issuance of an RA.

Scoring Legend

- **Strength** = indicator rate at or above 86.0%
- **Compliant** = indicator rate between 80.0% and 85.9%
- **Opportunity for improvement** = indicator rate at or below 79.9%

See [Appendix E: CM Review Methodology](#) for more information.

¹⁸ The MSR for a given indicator is calculated using the same-year results from the three MCPs (HB, HSH, UHC) for that specific indicator. The total number of 'met' and 'not met' records across all three MCPs is aggregated to determine the MSR.

¹⁹ Please note that the review period reporting terminology has been updated, with CY2024 results previously referenced as CY2023 in last year's report.

²⁰ A Pearson's chi-squared test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance.

²¹ In CY2024, document and clinical scoring were assessed using separate criteria. For the CY2025 review, these criteria have been consolidated to ensure consistency.

Focus Area 1: Multiple Comorbid Conditions

Focus Area 1 was an evaluation of members with two or more chronic conditions. Policies related to supporting members with comorbid conditions and a random sample of members enrolled in CM were evaluated for CM requirements relating to this area.

An additional sample of members not enrolled in CM, but who were eligible for Disease Management (DM), were evaluated for requirements related to the offering and opting out of DM. Please note that SMHK, as the sole provider of foster care services, was not included in this part of the review. Therefore, no results were reported for this focus area and it was not factored in the overall program level rate (MSR).

The Multiple Comorbid Conditions sample size for each MCP in this group included 35 members enrolled in CM and 10 members not enrolled.

Enrollment and Assessment (EA): CM Record Documentation - 2.12.1 (c); and General Eligibility and Assessment for CM – 2.12.1 (e)

This CM review area focused on enrollment and assessment. The MCP is required to comprehensively explore and document the needs of each member enrolled in CM. Additionally, the initial assessment and subsequent reassessments must meet the contract timelines. DM is required to be offered timely to newly eligible members. Timeliness was assessed for applicable members using a 30-calendar day threshold. MCPs are required to utilize the “opt out” methodology, meaning that CM services shall be provided unless the member specifically asks to be excluded.

Table 86 and Table 87 below present the MCPs’ compliance with EA standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 86. CM Focus Area 1: EA Document Review.

Citation	HB	HSH	UHC	MSR
CM Record Documentation - 2.12.1(c); and General Eligibility and Assessment for CM – 2.12.1(e)(2),(4)	75.0%	75.0%	75.0%	75.0%

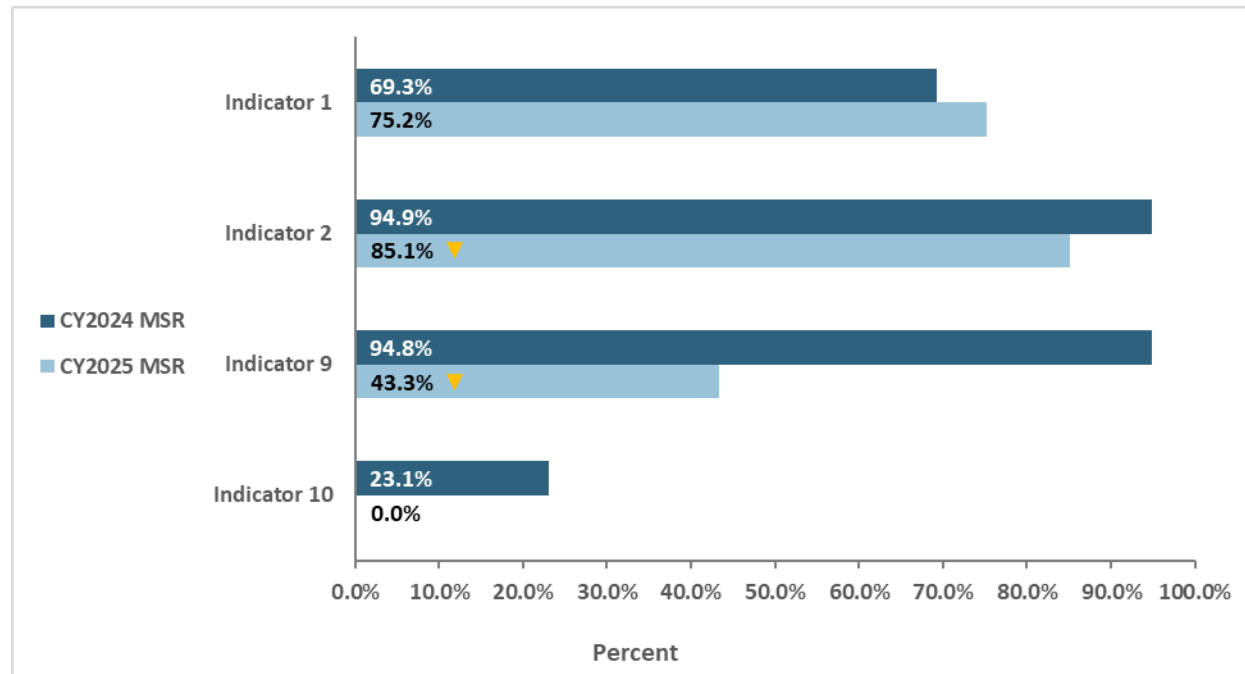
Table 87. CM Focus Area 1: EA Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
1	Assessment (or other documentation in the record) was comprehensive	71.4%	82.9%	90.6%	85.7%	47.1%	57.1%	69.3%	75.2%
2	Assessments occurred timely	100%	83.9% ▼	93.3%	91.4%	91.2%	80.0%	94.9%	85.1% ▼
9	Disease management (DM) was offered timely	100%	20.0% ▼	97.8%	100%	86.7%	10% ▼	94.8%	43.3% ▼
10	The “opt out” methodology for DM was utilized	50.0%	0.0% ▼	18.2%	N/A	18.2%	0.0%	23.1%	0.0%

Statistically significant decrease ▼

Figure 19 below displays the year-to-year results from the clinical review. Indicators 9 and 10 in the CY2025 review were Indicators 3 and 4 in the CY2024 review. Criteria for the DM focused indicators changed, making the indicators no longer comparable.

Figure 19. Focus Area 1: Enrollment and Assessment (Year-to-Year Comparison).



Statistically significant decrease ▼

Care Planning (CP): Principles of Member CM – 2.12.1 (a); and CM Record Documentation - 2.12.1 (c)

This area of CM review focused on CP practices. Each member enrolled in CM is required to have a comprehensive care plan and complete CP processes to support comprehensive care management. Member care plans are to be updated according to the contract timelines.

Table 88 and Table 89 below present the MCPs' compliance with CP standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 88. CM Focus Area 1: CP Document Review.

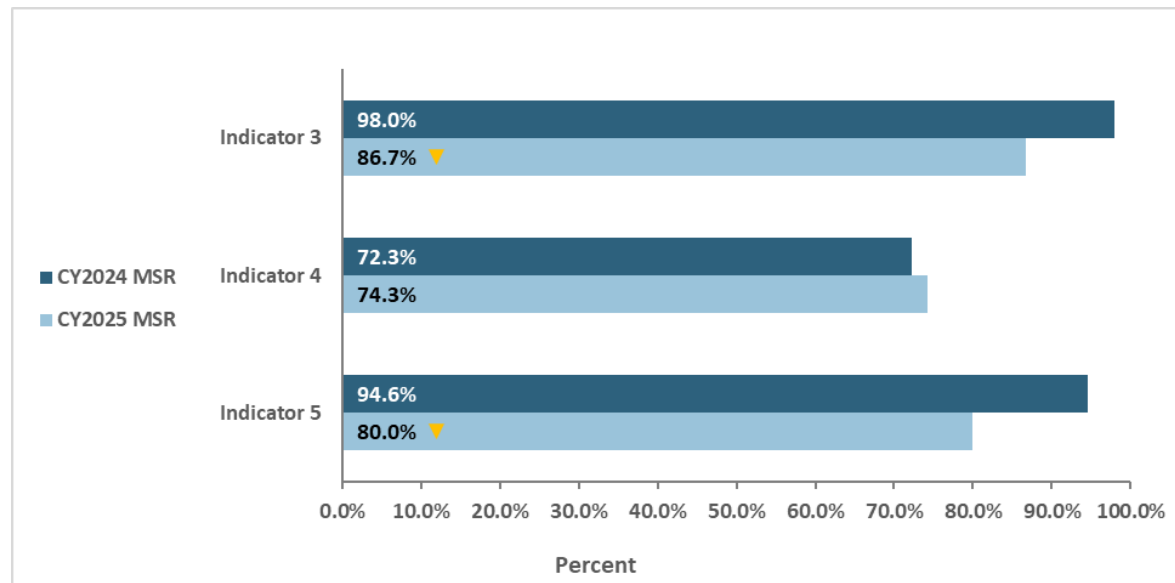
Citation	HB	HSH	UHC	MSR
Principles of Member CM – 2.12.1(a)(2),(3); and CM Record Documentation - 2.12.1(c)(12),(13)	100%	66.7%	100%	88.9%

Table 89. CM Focus Area 1: CP Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
3	Care Plan was comprehensive	100%	91.4%	96.9%	94.3%	97.1%	74.3% ▼	98.0%	86.7% ▼
4	Required care planning processes were evidenced	94.3%	94.3%	78.1%	97.1% ▲	44.1%	31.4%	72.3%	74.3%
5	Care plan was updated timely	100%	88.6% ▼	90.3%	82.9%	93.1%	68.6% ▼	94.6%	80.0% ▼

Statistically significant increase ▲ / Statistically significant decrease ▼

Figure 20 below displays the year-to-year results from the clinical review.

Figure 20. Focus Area 1: Care Planning (Year-to-Year Comparison).

Statistically significant decrease ▼

Care Coordination (CC): CM Record Documentation - 2.12.1 (c); and General Eligibility and Assessment for CM – 2.12.1 (e)

This area of CM review focused on CC practices. Care managers are responsible for the coordination and follow-up of member care and services, and provide referrals for additional services and supports as needed.

Table 90 and Table 91 below present the MCPs' compliance with CC standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 90. CM Focus Area 1: CC Document Review.

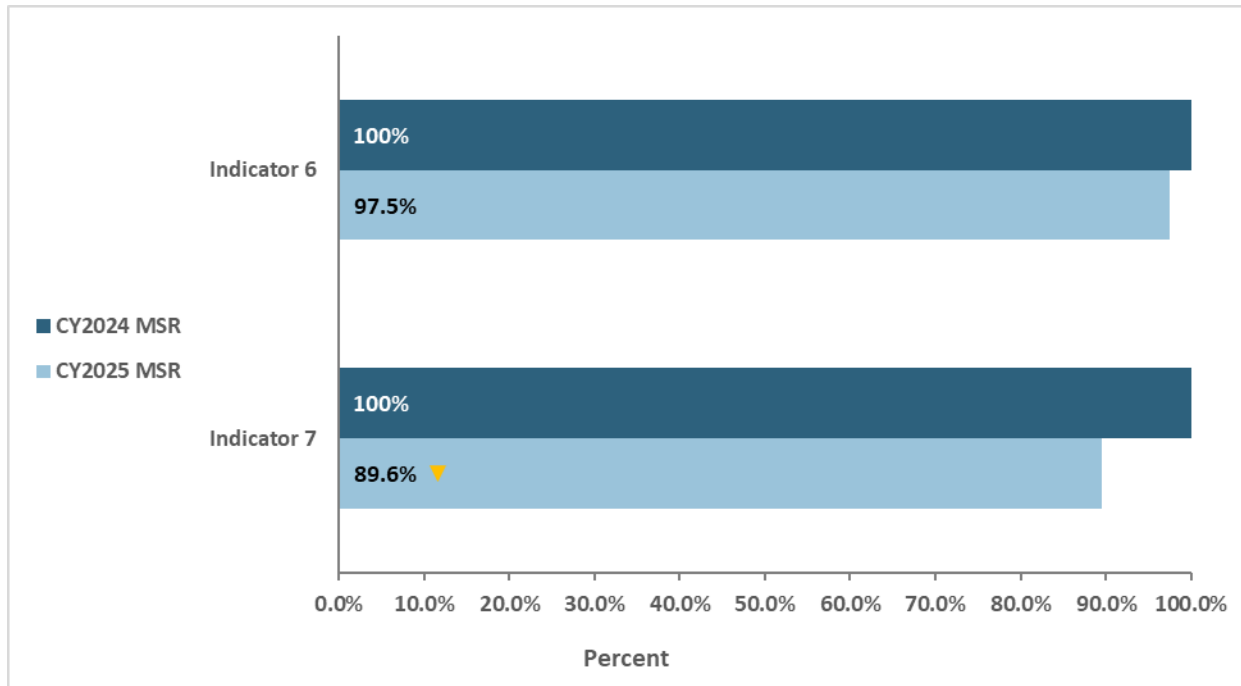
Citation	HB	HSH	UHC	MSR
CM Record Documentation - 2.12.1(c)(2),(14-22); and General Eligibility and Assessment for CM – 2.12.1(e)(4)	100%	50.0%	50.0%	66.7%

Table 91. CM Focus Area 1: CC Clinical Review.

Ind.	Indicator Description	CY2024 HB	CY2025 HB	CY2024 HSH	CY2025 HSH	CY2024 UHC	CY2025 UHC	CY2024 MSR	CY2025 MSR
6	Evidence of coordination and follow-up are documented in the record	100%	100%	100%	100%	100%	92.9%	100%	97.5%
7	Appropriate Referrals are documented in the record	100%	87.5%	100%	97.1%	100%	83.3%	100%	89.6% ▼

Statistically significant decrease ▼

Figure 21 below displays the year-to-year results from the clinical review.

Figure 21. Focus Area 1: Care Coordination (Year-to-Year Comparison).

Statistically significant decrease ▼

Care Management Closure (CL): CM Closure – 2.12.1 (g)

This area of CM review focused on CL practices. The MCP is required to document an acceptable reason for CM closure.

Table 92 and Table 92 below present the MCPs' compliance with CL standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 92. CM Focus Area 1: CL Document Review.

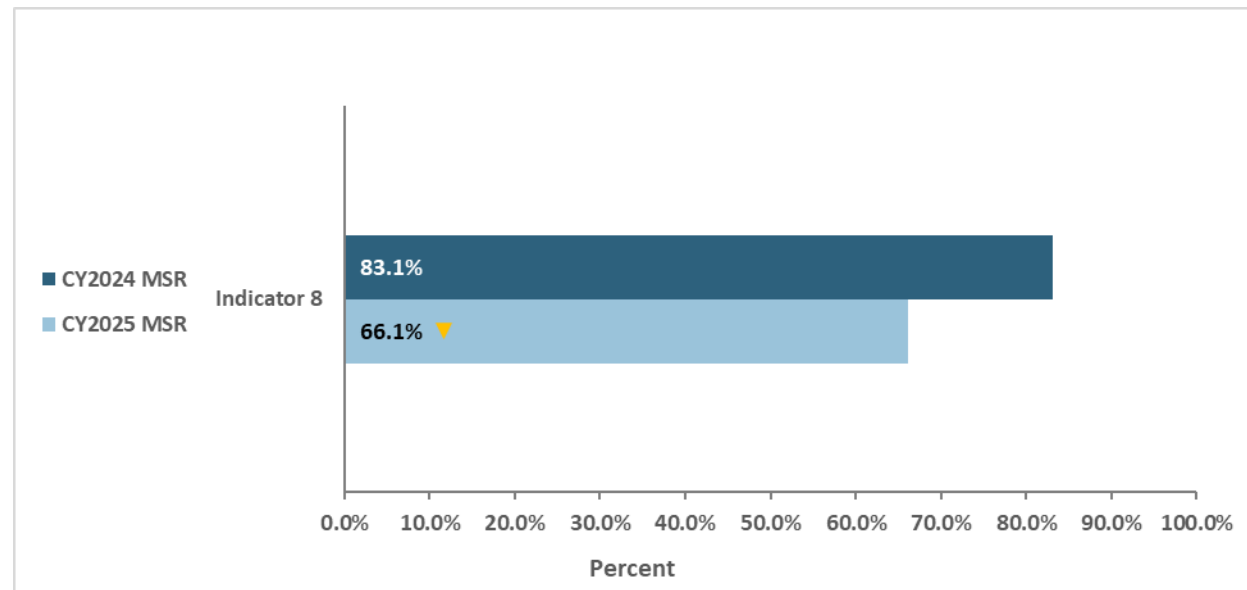
Citation	HB	HSH	UHC	MSR
CM Closure – 2.12.1(g)	0.0%	100%	100%	66.7%

Table 93. CM Focus Area 1: CL Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
8	The CM Closure requirements were satisfied	87.9%	73.9%	91.7%	86.4%	69.2%	21.4% ▼	83.1%	66.1% ▼

Statistically significant decrease ▼

Figure 22 below displays the year-to-year results from the clinical review.

Figure 22. Focus Area 1: CL (Year-to-Year Comparison).

Statistically significant decrease ▼

Focus Area 2: Pregnancy/Obstetrics

Focus Area 2 was an evaluation of pregnant members. Policies related to requirements for pregnant members and a random sample of members enrolled in CM were evaluated for requirements of CM relating to this area. Please note that SMHK, as the sole provider of foster care services, was not included in this part of the review. Therefore, no results were reported for this focus area and it was not factored in the overall program level rate (MSR).

In the Pregnancy/Obstetrics group, the sample size for each MCP was 45 enrolled in CM.

Enrollment and Assessment (EA): CM Record Documentation - 2.12.1 (c); and General Eligibility and Assessment for CM – 2.12.1 (e)

This area of CM review focused on EA practices. The MCP is required to comprehensively explore and document the needs of each member enrolled in CM. For pregnant members, this requires the completion of a risk appraisal form. Additionally, the initial assessment and subsequent reassessments must meet the contract timelines and CM is required to be offered timely to newly pregnant members.

Table 94 and Table 95 below present the MCPs' compliance with EA standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 94. CM Focus Area 2: EA Document Review.

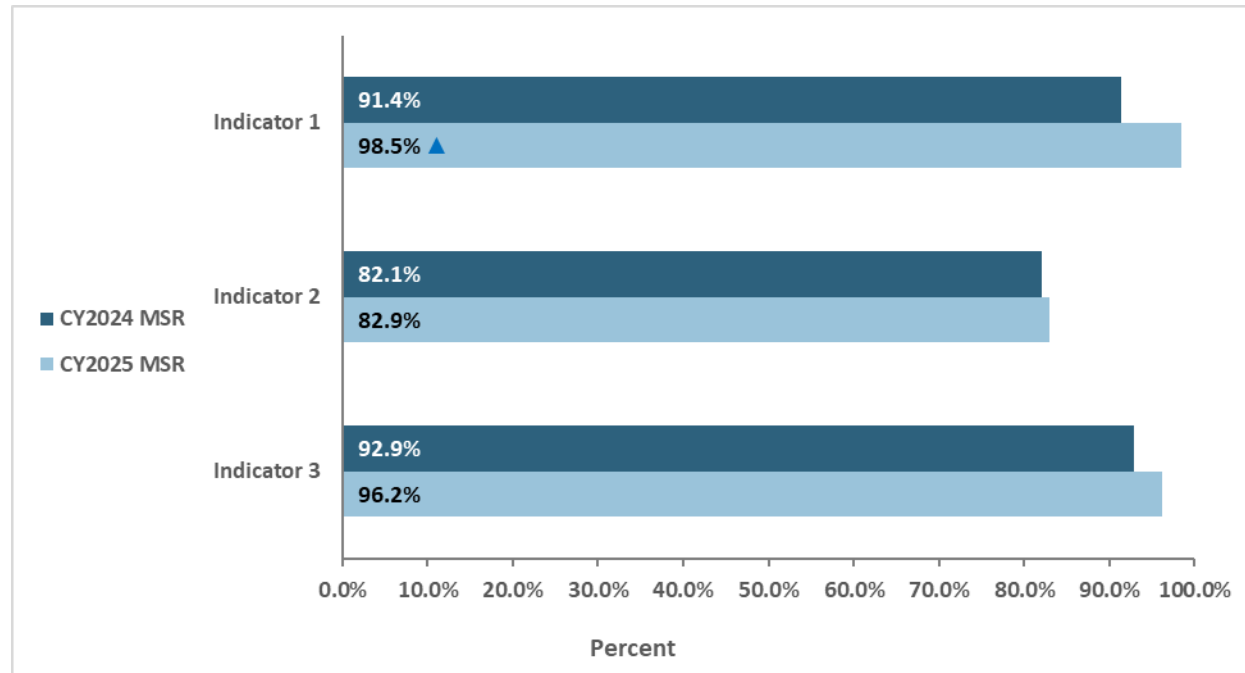
Citation	HB	HSH	UHC	MSR
CM Record Documentation - 2.12.1(c); and General Eligibility and Assessment for CM – 2.12.1(e)(6)	75.0%	75.0%	75.0%	75.0%

Table 95. CM Focus Area 2: EA Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
1	Assessment (or other documentation in the record) was comprehensive	85.7%	100% ▲	88.6%	100% ▲	100%	95.6%	91.4%	98.5% ▲
2	Assessments occurred timely	100%	89.3% ▼	60.7%	75.6%	81.0%	87.5%	82.1%	82.9%
3	CM was offered timely to pregnant members	100%	100%	84.2%	95.6%	93.3%	93.8%	92.9%	96.2%

Statistically significant increase ▲ / Statistically significant decrease ▼

Figure 23 below displays the year-to-year results from the clinical review.

Figure 23. Focus Area 2: Enrollment and Assessment (Year-to-Year Comparison).

Statistically significant increase ▲

Care Planning (CP): Principles of Member CM – 2.12.1 (a); and CM Record Documentation - 2.12.1 (c)

This area of CM review focused on CP practices. Each member enrolled in CM is required to have a comprehensive care plan and complete CP processes to support comprehensive care management. Member care plans are to be updated according to the contract timelines.

Table 96 and Table 97 below present the MCPs' compliance with CP standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 96. CM Focus Area 2: CP Document Review.

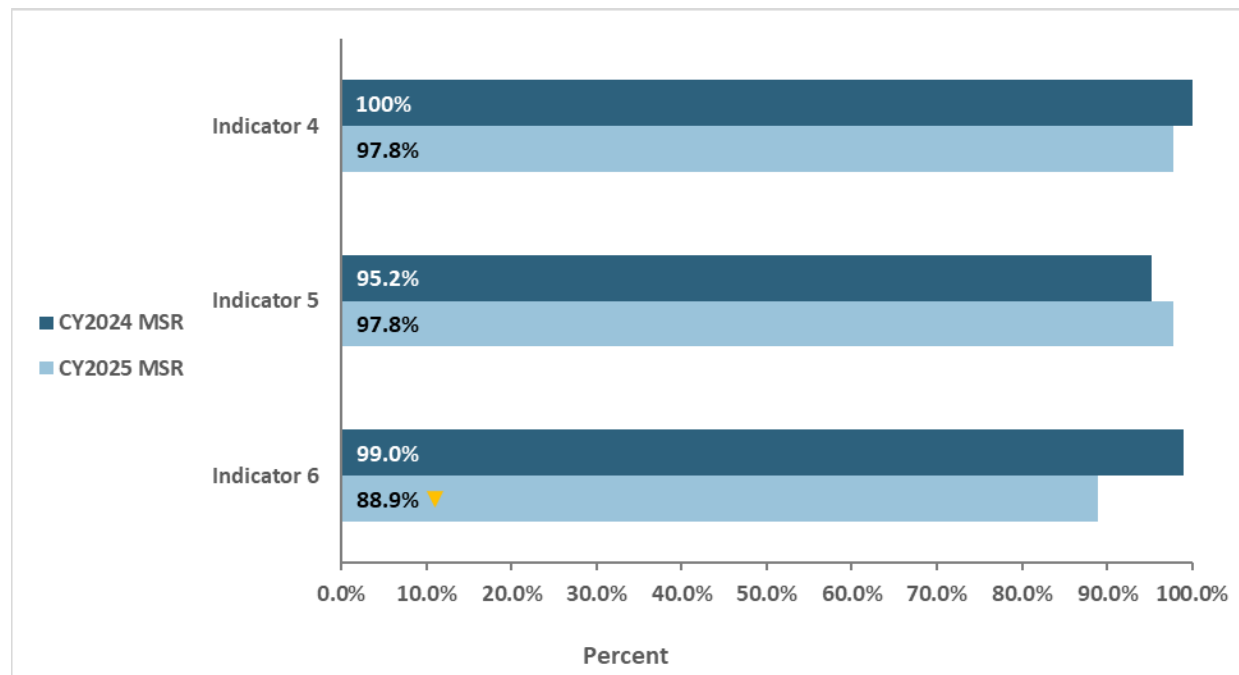
Citation	HB	HSH	UHC	MSR
Principles of Member CM – 2.12.1(a)(2),(3); and CM Record Documentation - 2.12.1(c)(12),(13)	100%	66.7%	100%	88.9%

Table 97. CM Focus Area 2: CP Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
4	Care plan was comprehensive	100%	100%	100%	93.3%	100%	100%	100%	97.8%
5	Required care planning processes were evidenced	94.3%	100%	97.1%	100%	94.3%	93.3%	95.2%	97.8%
6	Care plan was updated timely	96.8%	95.0%	100%	80.0% ▼	100%	91.1%	99.0%	88.9% ▼

Statistically significant decrease ▼

Figure 24 below displays the year-to-year results from the clinical review.

Figure 24. CM Focus Area 2: Care Planning (Year-to-Year Comparison).

Statistically significant decrease ▼

Care Coordination (CC): CM Record Documentation - 2.12.1 (c); and General Eligibility and Assessment for CM – 2.12.1 (e)

This area of CM review focused on CC practices. Care managers are responsible for the coordination and follow-up of member care and services, and providing assistance and referrals for pregnant members. Additionally, care managers are expected to follow-up with members when a post-partum medical appointment is not maintained.

Table 98 and Table 99 below present the MCPs' compliance with CC standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 98. CM Focus Area 2: CC Document Review.

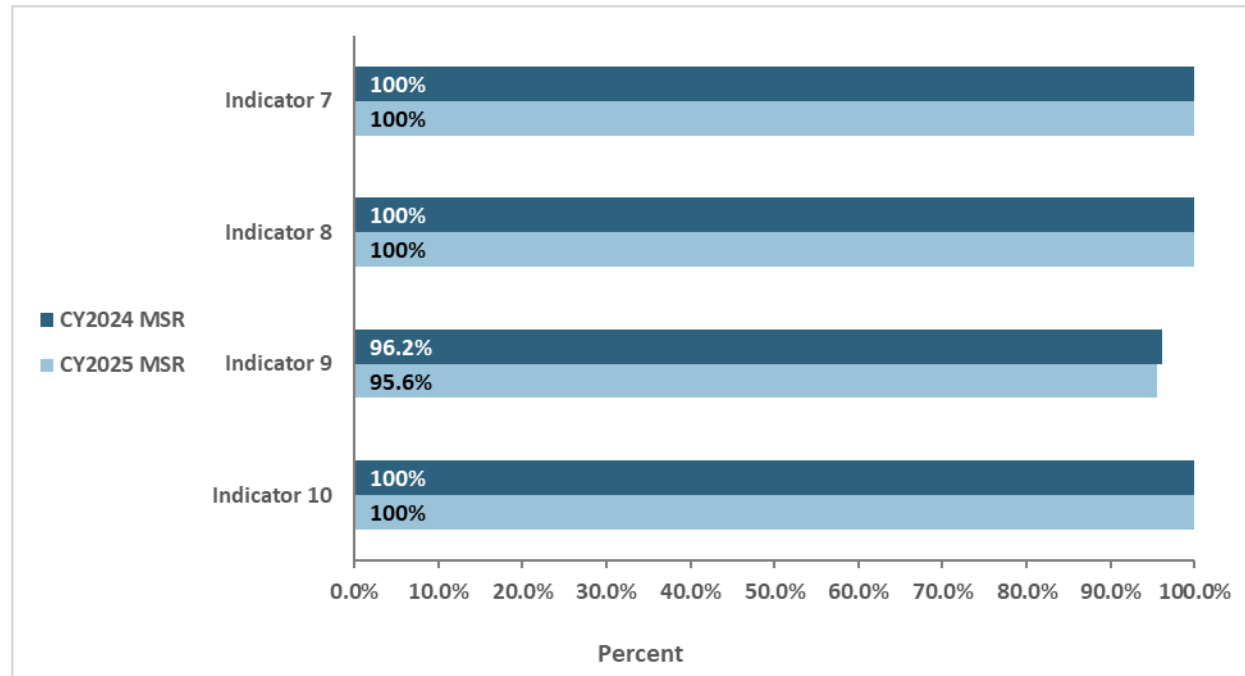
Citation	HB	HSH	UHC	MSR
CM Record Documentation - 2.12.1(c)(14-22); and General Eligibility and Assessment for CM – 2.12.1(e)(4),(6)	100%	75.0%	75.0%	83.3%

Table 99. CM Focus Area 2: CC Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
7	Evidence of coordination and follow-up are documented in the record	100%	100%	100%	100%	100%	100%	100%	100%
8	Timely follow-up for post-partum medical appointments	N/A	100%	N/A	N/A	100%	100%	100%	100%
9	Appropriate assistance is provided to pregnant members	97.1%	91.1%	91.4%	100% ▲	100%	95.6%	96.2%	95.6%
10	Appropriate Referrals are documented in the record	100%	100%	100%	100%	100%	100%	100%	100%

Statistically significant increase ▲

Figure 25 below displays the year-to-year results from the clinical review.

Figure 25. CM Focus Area 2: Care Coordination (Year-to-Year Comparison).**Care Management Closure (CL): CM Closure – 2.12.1 (g)**

This area of CM review focused on CL practices. The MCP is required to document an acceptable reason for CM closure.

Table 100 and Table 101 below present the MCPs' compliance with CL standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 100. CM Focus Area 2: CL Document Review.

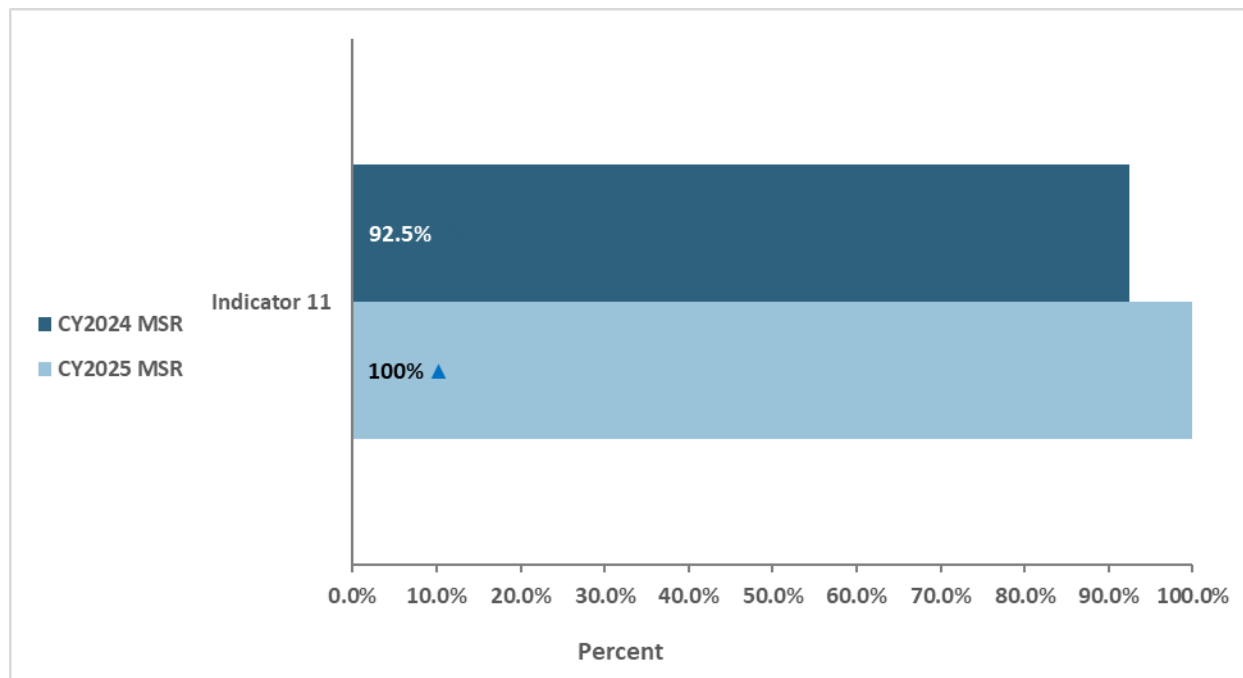
Citation	HB	HSH	UHC	MSR
CM Closure – 2.12.1(g)	0.0%	100%	100%	66.7%

Table 101. CM Focus Area 2: CL Clinical Review.

Ind.	Indicator Description	CY2024 HB Rate	CY2025 HB Rate	CY2024 HSH Rate	CY2025 HSH Rate	CY2024 UHC Rate	CY2025 UHC Rate	CY2024 MSR	CY2025 MSR
11	The CM Closure requirements were satisfied	85.2%	100% ▲	95.7%	100%	96.7%	100%	92.5%	100% ▲

Statistically significant increase ▲

Figure 26 below displays the year-to-year results from the clinical review.

Figure 26. CM Focus Area 2: CL (Year-to-Year Comparison).

Statistically significant increase ▲

Focus Area 3: Foster Care [SMHK only]

Focus Area 3 was an evaluation of members enrolled in the state's specialty plan, SMHK, which supports members in foster care, receiving foster care or an adoption subsidy or other out-of-home placement. Policies for the specialty plan and a random sample of members enrolled in CM were evaluated for requirements of CM related to this area. Please note that SMHK is the sole provider of foster care services in Missouri; as a result, there is no applicable MSR available for comparison. In the Foster Care group, the sample size enrolled in CM was 45.

Enrollment and Assessment (EA): Principles of CM – 3.9.3; and CM Assignment 3.9.8

This area of CM review focused on EA practices. The SMHK is required to comprehensively explore and document the needs of each member enrolled in CM. Additionally, the initial assessment and subsequent reassessments must meet the contract timelines and each member enrolled in CM is required to have tier assignments re-evaluated as required.

Table 102 and Table 103 below present SMHK's compliance with EA standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 102. CM Focus Area 3: EA Document Review.

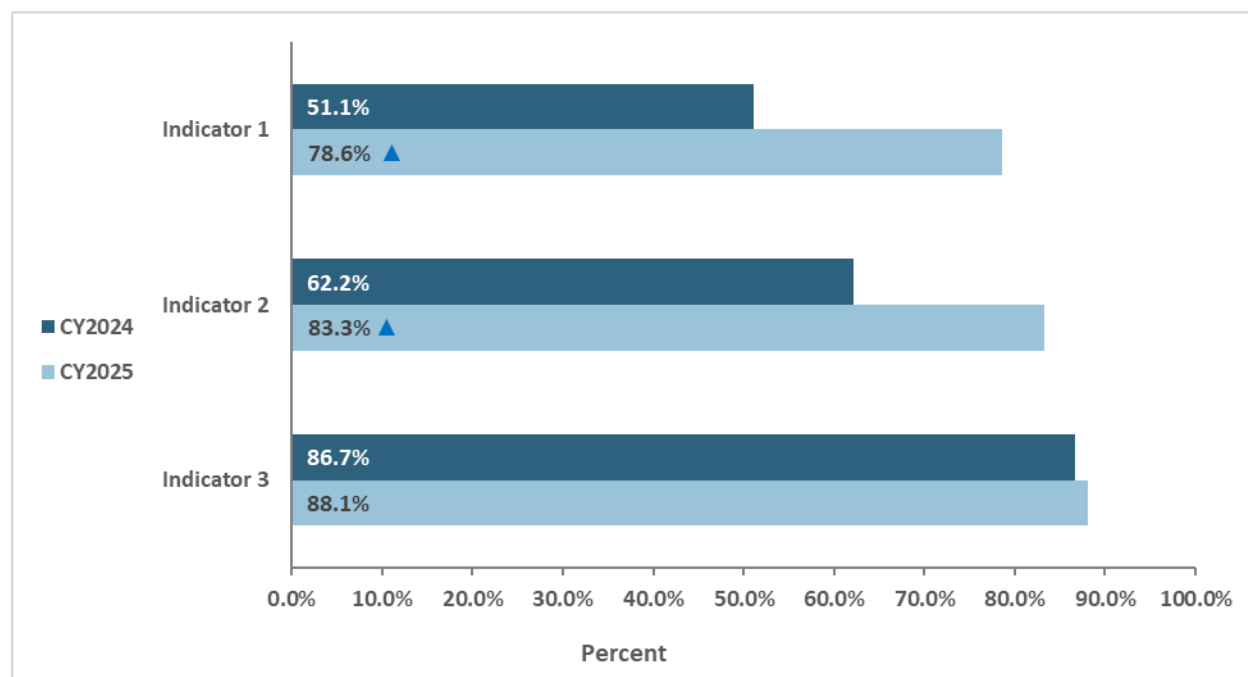
Citation	SMHK
CM Record Documentation - 2.12.1(c); Principles of CM – 3.9.3(a); and CM Assignment 3.9.8(a-g)	66.7%

Table 103. CM Focus Area 3: EA Clinical Review.

Ind.	Indicator Description	CY2024 SMHK Rate	CY2025 SMHK Rate
1	Assessment (or other documentation in the record) was comprehensive	51.1%	78.6% ▲
2	Assessments occurred timely	62.2%	83.3% ▲
3	Specialty plan member's tier assignment is re-evaluated as required	86.7%	88.1%

Statistically significant increase ▲

Figure 27 below displays the year-to-year results from the clinical review.

Figure 27. CM Focus Area 3: Enrollment and Assessment (Year-to-Year Comparison).**Care Planning (CP): Principles of CM – 3.9.3; and CM Policy Requirements – 3.9.15**

This area of CM review focused on CP practices. Each member enrolled in CM is required to have a comprehensive care plan and complete CP processes to support comprehensive CM. Member care plans are to be updated according to the contract timelines.

Table 104 and Table 105 below present SMHK's compliance with CP standards for document review and the rate achieved for the corresponding clinical review indicators.

Table 104. CM Focus Area 3: CP Document Review.

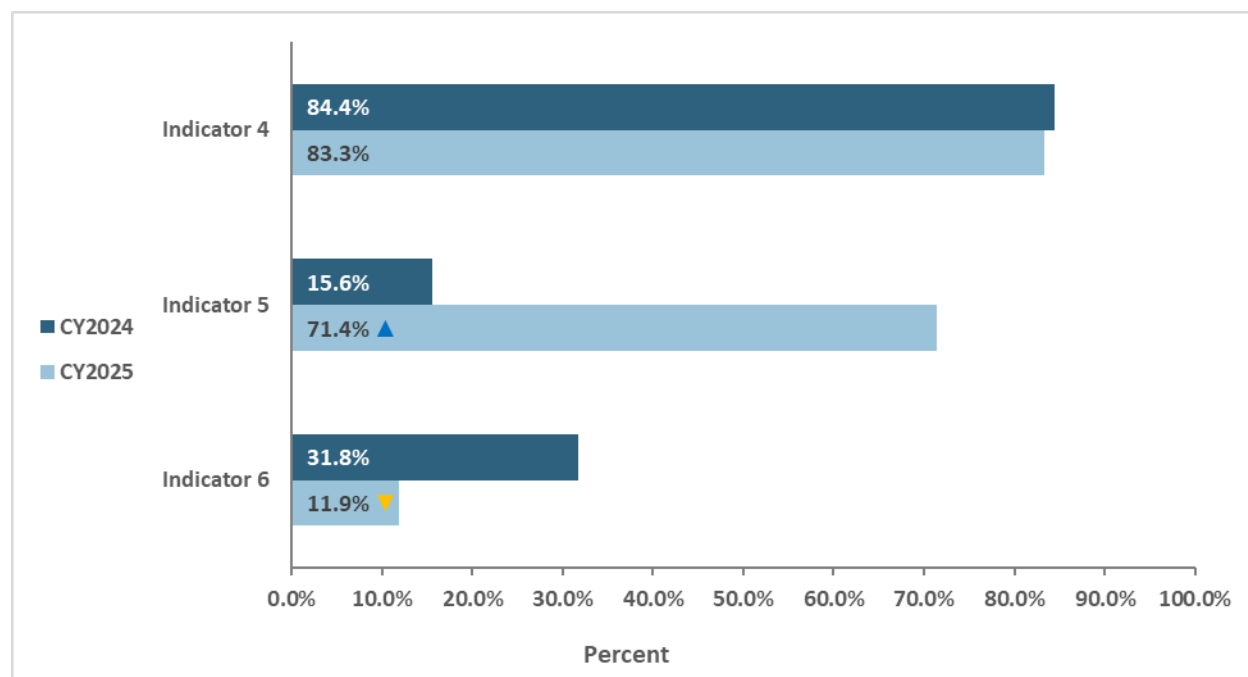
Citation	SMHK
Principles of Member CM – 2.12.1(a)(2); Principles of CM – 3.9.3; and CM Policy Requirements – 3.9.15(a)	100%

Table 105. CM Focus Area 3: CP Clinical Review.

Ind.	Indicator Description	CY2024 SMHK Rate	CY2025 SMHK Rate
4	Care plan was comprehensive	84.4%	83.3%
5	Required care planning processes were evidenced	15.6%	71.4% ▲
6	Care plan was updated timely	31.8%	11.9% ▼

Statistically significant increase ▲ / Statistically significant decrease ▼

Figure 28 below displays the year-to-year results from the clinical review.

Figure 28. CM Focus Area 3: Care Planning (Year-to-Year Comparison).

Statistically significant increase ▲ / Statistically significant decrease ▼

Care Coordination (CC): CM Record Documentation - 2.12.1 (c); CM Program Plan – 3.9.4; CM Coordination and Accountability – 3.9.9; CM Activities – 3.9.10; and Member Transition of Care – 3.9.16

This area of CM review focused on CC practices. Care managers are responsible for the coordination and follow-up of member care and services, and provide referrals for additional services and supports as needed.

Table 106 and Table 107 below present SMHK's compliance with CC standards for document review and the rate achieved for the corresponding clinical review indicators.

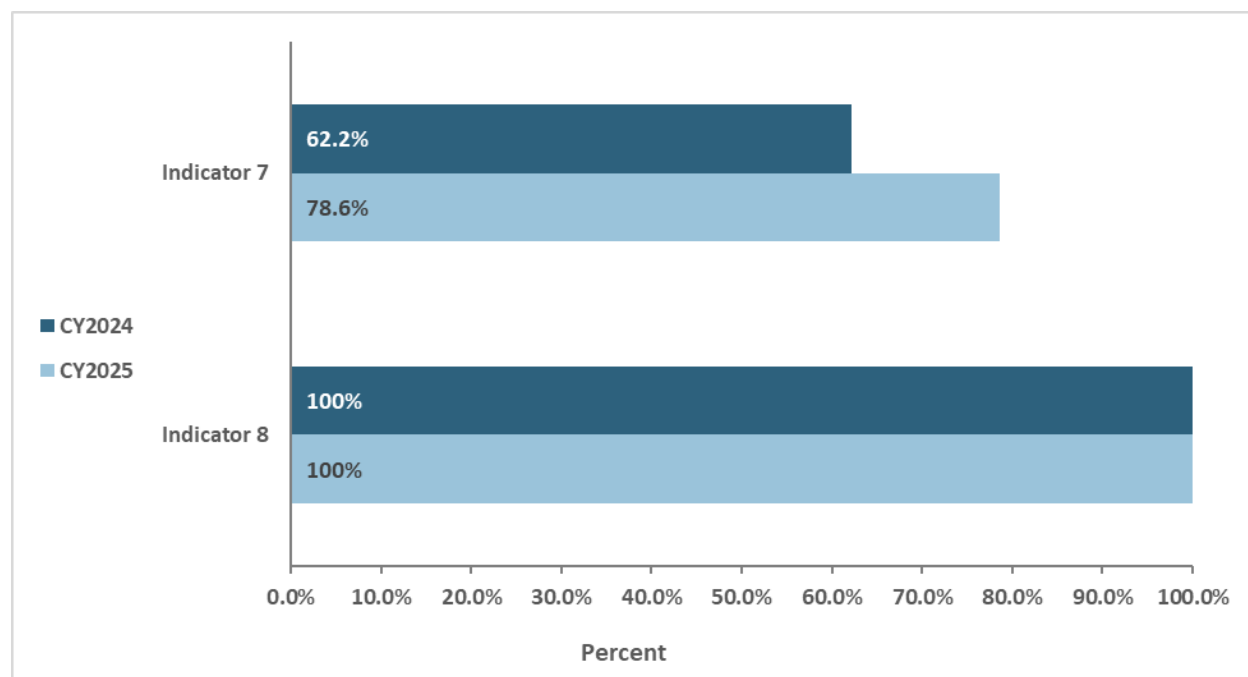
Table 106. CM Focus Area 3: CC Document Review.

Citation	SMHK
CM Record Documentation - 2.12.1(c)(14-22); CM Program Plan – 3.9.4(e); CM Coordination and Accountability – 3.9.9; CM Activities – 3.9.10(a-m); and Member Transition of Care – 3.9.16	100%

Table 107. CM Focus Area 3: CC Clinical Review.

Ind.	Indicator Description	CY2024 SMHK Rate	CY2025 SMHK Rate
7	Evidence of coordination and follow-up are documented in the record	62.2%	78.6%
8	Appropriate referrals are documented in the record	100%	100%

Figure 29 below displays the year-to-year results from the clinical review.

Figure 29. CM Focus Area 3: Care Coordination (Year-to-Year Comparison).

Program Level CM Review EQRO Recommendations

Based on the program level findings from the CM review, the following recommendations are provided to MHD.

Document Review



Based on the program level findings from the document review of the CM review, weaknesses or opportunities for improvement were identified for any standard that is below 80% and are presented as a recommendation to MHD.

The MCPs²² did not meet all elements for the following practice areas and will benefit from technical assistance by MHD to ensure the plans meet these requirements. An update of the current year's EQRO recommendations will be reflected in the 2026 EQR Annual Technical Report.

Focus Area 1:

- **EA Document Review (75.0%)**
 - All three of the MCPs scored 75.0% on the practice area.
- **CC Document Review (66.7%)**
 - Two of the three MCPs scored 50.0% on the practice area.
- **CL Document Review (66.7%)**
 - One of the three MCPs scored 0.0% on the practice area.

Focus Area 2:

- **EA Document Review (75.0%)**
 - All three of the MCPs scored 75% on the practice area.

²² Focus Areas 1 and 2 included HB, HSH and UHC. Focus Area 3 included SMHK.

- **CL Document Review (66.7%)**

- One of the three MCPs scored 0.0% on the practice area.

Focus Area 3: The specialty plan MCP scored 66.7% on the EA Document Review practice area.

Clinical Review



Based on the program level findings from the clinical review section of the CM review, weaknesses or opportunities for improvement were identified for any indicator that is below 80% and are presented as a recommendation to MHD.

The MCPs²² did not meet all elements for the following indicators and will benefit from technical assistance by MHD to ensure the plans meet these requirements.

Focus Area 1:

- **EA Clinical Review**

- Indicator 1 (75.2%) – One of the three MCPs scored below 80.0% on this indicator.
- Indicator 9 (43.3%) – Two of the three MCPs scored below 80.0% on this indicator.
- Indicator 10 (0.0%) – Both MCPs²³ scored 0.0% on this indicator.

- **CP Clinical Review**

- Indicator 4 (74.3%) – One of the three MCPs scored below 80.0% on this indicator.

- **CL Clinical Review**

- Indicator 8 (66.1%) – Two of the three MCPs scored below 80.0% on this indicator.

Focus Area 3:

- **EA Clinical Review**

- Indicator 1 (78.6%)

- **CP Clinical Review**

- Indicator 5 (71.4%)
- Indicator 6 (11.9%)

- **CC Clinical Review**

- Indicator 7 (78.6%)

Progress on Previous Year (2024) Program Level CM EQRO Recommendations

Table 108 and Table 109 present the EQRO document and clinical recommendations from the previous review alongside the actions implemented by MHD and the EQRO's response.

²³ HSH received an NA for this indicator and was not included in the MSR for this indicator.

Table 108. CM Program Level Progress on Previous Document Review Recommendations.

EQRO Recommendation
The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements.²⁴ • General Health Plan Policy Requirements (66.7%) (OCM5) ○ Two of the three MCPs scored 50.0% on the standard. • General Eligibility and Assessment for CM (33.3%) (OCM6) ○ Two of the three MCPs scored 0.0% on this standard. • General Eligibility and Assessment for CM (73.3%) (MCC1) ○ All three MCPs scored at 80.0% or below on this standard. • General Eligibility and Assessment for CM (78.9%) (PO2) ○ Two out of the three MCPs did not score 100% on this standard, including one of the two MCPs scoring 42.1%. • Transition of CM (66.7%) (PO6) ○ One of the three MCP scored 0.0% on this standard.
MHD Response
MHD has internal audits and clinical reviews to assess consistency and effectiveness of MCP care management practices. Additional efforts include reviewing managed care contract language in an effort to improve and strengthen the care management program. A comprehensive review of national standards and emerging best practices is informing these updates. As these enhancements are implemented, MHD will work closely with MCPs to provide guidance and ensure a smooth operational transition while maintaining a focus on member outcomes. Additionally, an internal Quality/Clinical team has formed to overhaul our Care Management and Disease Management program with focus on Population Health. This will ensure all members are informed and aware of mechanisms for gaining access to care and increasing their knowledge including self-management of their specific condition(s), resulting in improved health outcomes. These efforts signal MHD's broader shift toward embedding person-centeredness across operational and strategic priorities. Managed care plan expectations will be clearly defined, including performance goals and reporting requirements. We believe by improving transparency of the program, we may identify successful initiatives that increase engagement, participation and care of members.
EQRO Response
The EQRO acknowledges MHD's work in addressing the recommendation. The response is accepted.

Table 109. CM Program Level Progress on Previous Clinical Review Recommendations.

EQRO Recommendation
The MCPs did not meet all elements for the following indicators and will benefit from technical assistance by MHD to ensure the plans meet these requirements. • Ensure records document the member's developmental history as well as cultural and linguistic needs (MCC1).

²⁴ SMHK was not reviewed on these standards.

EQRO Recommendation

- Ensure the member's choice to "opt out" is documented in the record for members not receiving DM services **(MCC4)**.
- Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail **(MCC5)**.
- Ensure care plans are shared with the member's health care provider **(MCC7)**.
- Implement processes to complete additional outreach attempts for members who have lost contact with the CM prior to CM closure **(MCC11)**.
- Focus efforts to complete assessments timely **(PO2)**.
- Implement processes to make additional outreach attempts when telephonic attempts are unsuccessful **(PO4)**.
- Ensure records include documentation of legal information and issues **(FC1)**.
- Focus efforts to complete assessments timely **(FC2)**.
- Ensure care plans are comprehensive **(FC4)**.
- Ensure processes for sharing care plans with the member's health care provider are documented **(FC5)**.
- Ensure processes for sharing care plans with the Children's Division are documented **(FC6)**.
- Focus effort on CM accountability for coordination by ensuring gaps in care are coordinated **(FC7)**.

MHD Response

MHD has internal audits and clinical reviews to assess consistency and effectiveness of MCP care management practices. Additional efforts include reviewing managed care contract language in an effort to improve and strengthen the care management program. A comprehensive review of national standards and emerging best practices is informing these updates. As these enhancements are implemented, MHD will work closely with MCPs to provide guidance and ensure a smooth operational transition while maintaining a focus on member outcomes.

Additionally, an internal Quality/Clinical team has formed to overhaul our Care Management and Disease Management program with focus on Population Health. This will ensure all members are informed and aware of mechanisms for gaining access to care and increasing their knowledge including self-management of their specific condition(s), resulting in improved health outcomes. These efforts signal MHD's broader shift toward embedding person-centeredness across operational and strategic priorities. Managed care plan expectations will be clearly defined, including performance goals and reporting requirements. We believe by improving transparency of the program, we may identify successful initiatives that increase engagement, participation and care of members.

EQRO Response

The EQRO acknowledges MHD's work in addressing the recommendation. The response is accepted.

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Summary of Plan Level CM Review Findings and Recommendations

Findings are scored by focus area and categorized as “Strength,” “Compliant” and “Opportunity for Improvement,” with their corresponding compliance rating in the scoring legend below.²⁵

Recommendations are provided for all identified weaknesses and opportunities for improvement, followed by the issuance of an RA.

Scoring Legend

- **Strength** = indicator rate at or above 86.0%
- **Compliant** = indicator rate between 80.0% and 85.9%
- **Opportunity for improvement** = indicator rate at or below 79.9%

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented RAs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year’s EQRO recommendations will be reflected in the 2026 Annual Technical Report.

The following provides the major themes of the individual document review findings for the MCPs. For more detailed information on the findings, please refer to the individual [MCP CY2025 EQR CM reports](#).

Healthy Blue

Table 110 and Table 111 describe the strengths and recommendations for the CM review, with the applicable practice area based on weaknesses/opportunities for improvement for HB.

Table 110. HB: CM Review Strengths.

Strengths
Focus Area 1 – Multiple Comorbid Conditions
Enrollment and Assessment
No strengths were identified in this area of practice.
Care Planning
• HB has established policies and procedures that promote comprehensive, person-centered documentation aligned with CM principles specific to members with comorbid health conditions. Member records consistently reflect individualized care plans that address the full spectrum of the member’s health needs, with clearly documented goals tailored to their medical, behavioral and social circumstances.
Care Coordination
• HB’s policies and procedures provide a strong foundation for ensuring effective coordination and follow-up during transitions of care, discharge planning and aftercare. • Member records consistently reflect timely outreach and documentation of follow-up activities, including communication with health care providers. • In alignment with HB’s CM protocols, care managers also assess and respond to emerging needs by providing referrals for services such as durable medical equipment, dental care, behavioral health, food and housing support and transportation.

²⁵ In CY2024, document and clinical scoring were assessed using separate criteria. For the CY2025 review, these criteria have been consolidated to ensure consistency.

Strengths
• This comprehensive, member-centered approach promotes continuity of care, reduces the risk of readmission and ensures that members receive the necessary supports to maintain stability and well-being.
CM Closure
No strengths were identified in this area of practice.
Focus Area 2
Enrollment and Assessment
• Member records demonstrate a high level of comprehensiveness for pregnant members. • Assessments were consistently completed in a timely manner and CM services were offered promptly upon identification of pregnancy-related needs. • Notably, scores related to comprehensive documentation improved compared to the prior review cycle, indicating strengthened practices and a continued commitment to quality improvement in maternal CM.
Care Planning
• HB has established policies and procedures that promote comprehensive, person-centered documentation aligned with CM principles specific to maternal health. • Member records consistently reflect individualized care plans that address prenatal, postpartum and inter-conception needs, with clearly documented goals tailored to the member's health status, preferences and stage of pregnancy or postpartum recovery. • The CM process includes educating members about their role in care planning and service coordination, empowering them to actively participate in decisions that impact their maternal and infant health. • Additionally, care plans are routinely shared with the member's health care providers, including obstetricians, primary care providers and specialists, to ensure continuity, collaboration and alignment across the care team. • This approach enhances the quality, safety and coordination of maternal health services while meeting regulatory and clinical standards.
Care Coordination
• HB demonstrates strong CM practices supported by policies and procedures that ensure timely, coordinated and comprehensive support for pregnant and postpartum members. • Member records consistently show evidence of coordination and follow-up related to discharge planning, aftercare and TOC. Timely follow-up for postpartum medical appointments is well-documented, reflecting proactive engagement to support maternal recovery and infant well-being. • Care managers provide appropriate assistance to pregnant members, including support with delivery arrangements and transportation, referrals to primary care for both the mother and newborn and education on the importance of folic acid. • Individualized care planning is evident, with referrals to essential services including prenatal care, childbirth education, dental care, WIC and family planning. • Additionally, referrals for value-added benefits, such as nurse support hotlines, breast pumps, meal services and transportation, are clearly documented in the record, demonstrating that care managers appropriately performed their role in identifying and addressing member needs.

Strengths
This integrated, member-centered approach enhances the quality, safety and coordination of maternal health services while promoting positive health outcomes and meeting regulatory and clinical standards.
CM Closure
- Member records demonstrate consistent adherence to CL requirements, particularly following the delivery of the baby. - Documentation reflects appropriate CL practices, including confirmation of postpartum follow-up, completion of care plan goals and coordination of services to support the transition out of active CM.

Table 111. HB: CM Review Recommendations.

Based on the review findings, it is recommended that HB take the following actions:
Focus Area 1 – Multiple Comorbid Conditions
Enrollment and Assessment
- Revise policies and procedures to explicitly address how legal issues relevant to a member's care are to be identified, documented and integrated into the member's record. Train staff on the updated procedures to ensure consistent application (EA 1). - Implement standardized documentation templates or checklists within the electronic health record (EHR) to ensure all active and historical conditions are clearly listed, with associated start and stop dates. Conduct periodic audits to monitor compliance and provide feedback to care teams (Indicator 1). - Establish clear timelines and tracking mechanisms for completing initial assessments upon member enrollment. Consider automated alerts or dashboards to flag overdue assessments and support timely follow-up by care managers (Indicator 2). - Strengthen the referral and eligibility identification process for disease management by integrating real-time data triggers or automated workflows. Ensure care managers are notified promptly when members become eligible for services (Indicator 9). - Develop and implement a standardized process for documenting member decisions to opt in or out of disease management services. This should include clear language in the care plan and member record and staff training to ensure consistent documentation practices (Indicator 10).
Care Planning
No recommendations were identified in this area of practice.
Care Coordination
No recommendations were identified in this area of practice.
CM Closure
HB should revise its CM closure policies and procedures to include a requirement to attempt contact with the member's family or authorized representative, when appropriate, in situations where contact with the member has been lost. In addition, HB should implement a standardized process to ensure consistent documentation of all closure-related activities, including outreach attempts and rationale for closure. This will help ensure alignment with policy expectations, promote continuity of care and support accountability in CM practices (CL, Indicator 8).
Focus Area 2 – Pregnancy/Obstetrics

Based on the review findings, it is recommended that HB take the following actions:	
Enrollment and Assessment	
HB should revise its policies and procedures to explicitly address how legal issues relevant to a member's care are to be identified, documented and integrated into the member's record. Staff should be trained on the updated procedures to ensure consistent application (EA 1).	
Care Planning	
No recommendations were identified in this area of practice.	
Care Coordination	
No recommendations were identified in this area of practice.	
CM Closure	
HB should revise its CM closure policies and procedures to include a requirement to attempt contact with the member's family or authorized representative, when appropriate, in situations where contact with the member has been lost. (CL).	

Home State Health

Table 112 and Table 113 describe the strengths and recommendations for the CM review, with the applicable practice area based on weaknesses/opportunities for improvement for HSH.

Table 112. HSH: CM Review Strengths.

Strengths
Focus Area 1 – Multiple Comorbid Conditions
Enrollment and Assessment
- HSH demonstrated strong performance in ensuring timely assessments for members with comorbid conditions, supporting early identification and intervention. - Additionally, DM services were offered promptly following assessment, ensuring that members receive necessary support without delay. - Notably, all members samples for DM engage in the program, reflecting the effectiveness of outreach and the relevance of services provided. As a result, opt-out methodology was not applicable.
Care Planning
- HSH demonstrates a robust and member-centered approach to CP for individuals with comorbid conditions. - Care plans are consistently comprehensive, incorporating member and family-centered activities, clearly defined and measurable goals, targeted interventions and ongoing evaluation of progress. - The CP process is well-evidenced, including education on the CM process, active member involvement and the sharing of care plans with relevant health care providers. This collaborative and structured approach supports continuity of care, promotes member engagement and enhances the effectiveness of disease and condition management strategies.
Care Coordination
HSH demonstrated strong CM practices through consistent documentation of coordination and follow-up related to discharge needs, aftercare and transition of care (TOC) assistance.

Strengths
• Additionally, individualized referrals are well-documented for newly identified CM needs, including support for baby items, breast pumps, baby clothes, belly bands, dental care and food insecurity. These practices reflect a holistic, member-centered approach that addresses both clinical and social determinants of health, promoting continuity of care and improved member well-being.
CM Closure
• HSH's policies appropriately include closure requirements for members with comorbid conditions, supporting structured and accountable CM practices. This policy alignment was reflected in member record reviews, where evidence demonstrated that closure processes were consistently followed. • Documentation showed that CM was concluded in accordance with established criteria, ensuring that members received appropriate support throughout their care journey and that transitions out of care were handled thoughtfully and in alignment with clinical and programmatic standards.
Focus Area 2 – Pregnancy/Obstetrics
Enrollment and Assessment
• HSH demonstrates strong CM practices for pregnant members, with comprehensive assessments and documentation evident in the member records. • CM was consistently offered in a timely manner, supporting early engagement and individualized CP. • These practices reflect a proactive approach to maternal health, ensuring that members receive appropriate support throughout their pregnancy.
Care Planning
• HSH demonstrates strong CP practices for pregnant members, with documentation reflecting a comprehensive and member-centered approach. • Care plans consistently include member and family-centered activities, measurable and defined goals, targeted interventions and evaluation of progress. • Additionally, the CP process is well-supported through education on the CM process, inclusion of member and family education and sharing of the care plan with health care providers. These practices promote engagement, coordination and continuity of care, contributing to improved maternal health outcomes.
Care Coordination
• HSH demonstrates strong care coordination and follow-up for pregnant members, with documentation reflecting thorough support related to discharge needs, aftercare and TOC assistance. • Member records show that appropriate and individualized assistance was provided, including delivery arrangements, transportation for prenatal, delivery and postpartum care, alternative living arrangements and access to primary care for both mother and newborn. • Education on folic acid was also consistently documented. • Additionally, referrals were made for prenatal care, childbirth education, dental services, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), family planning and value-added benefits such as a 24-hour nurse line, breastfeeding events, belly bands, breast pumps, maternal comfort supplies, Mom's Meals and transportation. These

Strengths	
practices reflect a holistic, member-centered approach that addresses both clinical and social needs, promoting positive maternal and infant health outcomes.	
No members in the sample had documented instances of missed post-partum medical appointments; therefore, this measure was not applicable.	
CM Closure	
HSH's policies appropriately include closure requirements for pregnant members, supporting structured and accountable CM practices. This alignment was reflected in member record reviews, where documentation showed that CM was consistently concluded following delivery in accordance with established criteria. These practices ensure that members receive appropriate support throughout their pregnancy and that transitions out of care are handled thoughtfully, promoting continuity and quality in maternal health services.	

Table 113. HSH: CM Review Recommendations.

Based on the review findings, it is recommended that HSH take the following actions:	
Focus Area 1 – Multiple Comorbid Conditions	
Enrollment and Assessment	
Update policies and procedures to clearly define how each condition for which the member is being managed, including start and stop date for each condition, should be identified, documented and incorporated into the member's record. Ensure staff are trained on these revised procedures to promote consistent and accurate implementation (EA 1).	
Care Planning	
Although HSH demonstrated compliant practice in updating member care plans at least quarterly, it is recommended that the organization revise its policies and procedures to explicitly include this requirement. Formalizing the quarterly update in policy will help ensure continued adherence, support staff accountability and promote consistency across teams. Clear documentation of this expectation also strengthens quality oversight and aligns with industry standards for proactive CM (CP 3).	
Care Coordination	
Update CM documentation policies to explicitly include coordination between health care facilities. Formalizing this practice in policy will strengthen organizational alignment with CM standards and promote comprehensive, member-centered transition planning (CC 1).	
CM Closure	
No recommendations were identified for this area of practice.	
Focus Area 2 – Pregnancy/Obstetrics	
Enrollment and Assessment	
- Member records showed comprehensive documentation of condition management, including start and stop dates. However, HSH's policies should be updated to clearly define how each managed condition is identified and documented in the care record. Staff training on the revised procedures is recommended to ensure consistent and accurate implementation (EA 1). - Ensure assessments for newly enrolled pregnant members are consistently conducted within 15 business days. While this standard may be met in some cases, formalizing and reinforcing the requirement through staff training and monitoring will promote consistent compliance and improve maternal health outcomes (Indicator 2).	

Based on the review findings, it is recommended that HSH take the following actions:	
Care Planning	
- Although HSH demonstrated compliant practices in updating member care plans at least quarterly, it is recommended that the organization revise its policies and procedures to explicitly include this requirement. Formalizing the quarterly update in policy will help ensure continued adherence, support staff accountability and promote consistency across teams. Clear documentation of this expectation also strengthens quality oversight and aligns with industry standards for proactive CM (CP 3). - Enhance tracking mechanisms aligned with the revised 90-day update requirement. This may include implementing automated alerts or dashboards to monitor upcoming due dates and providing staff with clear guidance on the updated timeframe. Additionally, strategies to improve member outreach, such as flexible contact hours or alternative communication methods, should be explored to support timely engagement and care plan updates (Indicator 6).	
Care Coordination	
Update CM documentation policies to explicitly include coordination between health care facilities. Formalizing this practice in policy will strengthen organizational alignment with CM standards and promote comprehensive, member-centered transition planning (CC 1).	
CM Closure	
No recommendations were identified for this area of practice.	

Show Me Healthy Kids

Table 114 and Table 115 describe the strengths and recommendations for the CM review, with the applicable practice area based on weaknesses/opportunities for improvement for SMHK.

Table 114. SMHK: CM Review Strengths.

Strengths
Focus Area 3 – Foster Care
Enrollment and Assessment
SMHK demonstrates strong compliance with tier assignment protocols for members in foster care or substitute care by consistently re-evaluating their tier status both annually and following any qualifying changes. This proactive and responsive approach ensures that tier assignments accurately reflect the evolving needs and circumstances of this vulnerable population, promoting equitable access to appropriate benefits, services and supports.
Care Planning
- SMHK's CM policies and procedures reflect a comprehensive and well-structured approach to the CP process. - SMHK clearly outlines all required elements, including individualized care plan development, member and caregiver engagement and regular plan updates. This structured framework supports consistent, person-centered care coordination and ensures that members' evolving needs are effectively identified and addressed.
Care Coordination
SMHK's policies and procedures include all requirements related to care coordination for members.

Strengths

- SMHK's records show evidence of appropriate referrals for newly identified CM needs, including support in locating in-network providers such as dental and behavioral health services.

Table 115. SMHK: CM Review Recommendations.

Based on the review findings, it is recommended that SMHK take the following actions:	
Focus Area 3 – Foster Care	
Enrollment and Assessment	
• Update policies and procedures to clearly define how each condition for which the member is being managed, including start and stop date for each condition, should be identified, documented and incorporated into the member's record. Ensure staff are trained on these revised procedures to promote consistent and accurate implementation (EA 1). • Implement strategies to improve member engagement during the review period, such as enhanced outreach efforts or alternative contact methods, to facilitate the completion of comprehensive assessments. Additionally, the plan should ensure that documentation is current and includes key elements such as developmental history, psychosocial issues and social determinants of health (Indicator 1).	
Care Planning	
• Enhance outreach strategies to improve timely engagement with members and families, particularly those who are difficult to reach. This may include leveraging multiple communication methods, flexible scheduling or coordination with community partners. Additionally, SMHK should ensure that education on the CM process and member/family involvement are documented within the review period to support comprehensive CP and demonstrate adherence to CM standards (Indicator 5). • Improve practices to support timely care plan updates every 90 calendar days. This may include incorporating information from additional sources, such as health care providers, case managers and community partners, when direct member or family contact is not possible. Leveraging these external inputs can help ensure care plans are updated every 90 days with relevant clinical and social information, maintaining continuity of care and responsiveness to member needs despite engagement challenges (Indicator 6).	
Care Coordination	
• Enhance care coordination practices by establishing protocols to ensure consistent member engagement throughout the review period. When direct contact with the member is not possible, care managers should proactively seek information from alternative sources such as health care providers, community partners or service agencies to maintain continuity of care. Additionally, documentation of outreach attempts, coordination activities and follow-up should be timely and comprehensive to support accountability and responsiveness in CM services (Indicator 7).	

UnitedHealthcare

Table 116 and Table 117 describe the strengths and recommendations for the CM review, with the applicable practice area based on weaknesses/opportunities for improvement for UHC.

Table 116. UHC: CM Review Strengths.

Strengths
Focus Area 1 – Multiple Comorbid Conditions
Enrollment and Assessment
No strengths were identified in this area of practice.
Care Planning
- UHC’s policies demonstrate a strong foundation for CM by clearly outlining comprehensive care planning requirements. These include member- and family-centered activities, measurable and defined goals, targeted interventions and ongoing evaluation of progress. - The policies also emphasize the importance of education to support understanding of CM processes and the development of skills and access to resources needed to achieve member and family goals. - Additionally, care plans are required to be shared with the Primary Care Provider (PCP) or designee and other involved health professionals, with mechanisms in place for provider updates and communication with CM staff. Care plan updates are expected at least quarterly and following any significant event, such as member/family contact, provider interaction or service utilization.
Care Coordination
- UHC demonstrated strong performance in CC, with member records consistently showing timely outreach and thorough documentation of follow-up actions, including communication with health care providers. - In alignment with the organization’s CM protocols, care managers proactively identify and address emerging member needs by initiating referrals for services such as transportation, food and housing supports, behavioral health and dental care. - This holistic, member-focused approach supports continuity of care, helps prevent readmissions and ensures members have access to the resources needed to maintain stability and overall well-being.
CM Closure
UHC’s policies and procedures detailed the required criteria for terminating CM services.
Focus Area 2 – Pregnancy/Obstetrics
Enrollment and Assessment
- UHC has demonstrated strong practices in maternal CM, particularly for pregnant members. - Member records consistently show timely completion of assessments and prompt initiation of CM services once pregnancy-related needs are identified.
Care Planning
- UHC’s policies and procedures demonstrate a strong foundation for CM by clearly outlining all required elements of comprehensive CP. - UHC demonstrated personalized maternal care through the development of individualized care plans for pregnant members. These plans consistently address prenatal, postpartum and inter-conception needs, with goals tailored to each member’s health status, preferences and stage of pregnancy or recovery. - The CM process actively involves members by educating them about their role in CP and service coordination, empowering informed decision-making for both maternal and infant health.

Strengths
Care plans are routinely shared with key health care providers, including obstetricians, primary care physicians and specialists, to promote collaboration, continuity and alignment across the care team. This coordinated approach supports high-quality, safe and compliant maternal health services.
Care Coordination
- UHC has demonstrated effective coordination and follow-up in maternal care, particularly around discharge planning, aftercare and transitions of care. - Member records consistently show timely follow-up for postpartum medical visits, reflecting proactive efforts to support both maternal recovery and infant health. - Care managers provide tailored assistance to pregnant members, including help with delivery planning, transportation and referrals to primary care for both mother and newborn. - Education on key topics, such as the importance of folic acid, is also provided. - Individualized CP is evident, with referrals documented for essential services such as prenatal care, childbirth education, dental care, the Supplemental Nutrition Program for Women, Infants, and Children (WIC), and family planning. Records also show referrals for value-added benefits like One Pass, a subscription-based fitness and well-being program, and Wellhop for Mom and Baby, a prenatal and postpartum support program. - Additional value-added benefits included the 24-hour nurse hotline, breast pumps, meal services and transportation. This integrated, member-centered approach enhances the quality, safety and coordination of maternal health services while supporting positive outcomes and meeting clinical and regulatory standards.
CM Closure
- UHC has clearly defined policies and procedures that specify the criteria for terminating CM services. These guidelines ensure that member records reflect proper closure practices, including confirmation of postpartum care, fulfillment of care goals and coordination of necessary services to support the member's transition out of active CM. - Member documentation consistently aligns with established protocols for concluding CM services, particularly after childbirth. - Records indicate that appropriate steps were taken to close cases, such as verifying postpartum follow-up visits, achieving care plan objectives and ensuring a smooth transition through coordinated support services.

Table 117. UHC: CM Review Recommendations

Based on the review findings, it is recommended that UHC take the following actions:
Focus Area 1 – Multiple Comorbid Conditions
Enrollment and Assessment
- Update policies and procedures to clearly define how each condition for which the member is being managed, including start and stop date for each condition, should be identified, documented and incorporated into the member's record. Ensure staff are trained on these revised procedures to promote consistent and accurate implementation (EA 1). - Introduce consistent documentation tools, such as templates or checklists, within the EHR to ensure developmental history and all current and past health conditions are clearly recorded,

Based on the review findings, it is recommended that UHC take the following actions:	
including their respective start and end dates. Regularly review records through audits to assess adherence and offer constructive feedback to care teams (Indicator 1). - Enhance the process for identifying and referring members to DM programs by incorporating automated workflows or real-time data alerts. Ensure care managers receive timely notifications when members qualify for services (Indicator 9). - Create and apply a consistent method for recording member choices to participate in or decline DM services. This should include clearly stated information in both the care plan and member record, along with staff training to support uniform documentation practices (Indicator 10).	
Care Planning	
- Introduce consistent documentation tools, such as templates or checklists, within the EHR to ensure care plans include an ongoing evaluation of progress on member outcomes (Indicator 3). - Ensure member care plans are shared with the member's PCP, their designee and other relevant health care professionals and documented in the record. Include a defined process for providers to contribute updates and communicate with CM staff. Ensure CM staff receive training on these requirements to ensure compliance (Indicator 4). - Implement a standardized process to ensure care plans for members with comorbid conditions are reviewed and updated at least every 90 calendar days. This process should include automated reminders for care managers, integration of updated clinical data and documentation of member engagement. Regular updates will help ensure care plans remain clinically relevant, support timely interventions and promote improved health outcomes for members with complex needs (Indicator 5).	
Care Coordination	
Update policies and procedures to include requirements that the CM record must include documentation of health testing, including results and aftercare, including post-acute care needs. Ensure care teams receive training on policy updates (CC 1).	
CM Closure	
UHC should establish a standardized procedure to ensure consistent documentation of all activities related to CM closure. This includes recording outreach efforts and the reasons for closing a case. Implementing this process will help align practices with policy expectations, support continuity of care and reinforce accountability within CM operations (Indicator 8).	
Focus Area 2 – Pregnancy/Obstetrics	
Enrollment and Assessment	
Update policies and procedures to clearly defined how each condition for which the member is being managed, including start and stop date for each condition, should be identified, documented and incorporated into the member's record. Ensure staff are trained on these revised procedures to promote consistent and accurate implementation (EA 1).	
Care Planning	
No recommendations were identified for this area of practice.	
Care Coordination	
Update policies and procedures to include requirements that the CM record must include documentation of health testing, including results and aftercare, including post-acute care needs. Ensure care teams receive training on policy updates (CC 1).	

Based on the review findings, it is recommended that UHC take the following actions:

CM Closure

No recommendations were identified in this area of practice.

Progress on Previous Year (2024) Plan Level CM EQRO Recommendations

Table 118 presents the plan level EQRO recommendations from the previous review, along with the degree to which plans have addressed the previous year's EQRO recommendations. The MCPs' efforts to address these recommendations were assessed through the RA process during the current review period and are summarized below. MCP-specific progress is provided in the individual [MCP 2025 CM reports](#).

Key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Table 118. CM Plan Level Progress on 2024 Document Review Recommendations.

MCP	Total Received	Met	Not Met	Degree to which plans addressed all EQRO recommendation(s)
HB	6	5	1	Medium
HSH/SMHK	10	8	2	Medium
UHC	4	1	3	Medium

See [Appendix G: Recommendations and Tracking Progress](#) for more information on addressing recommendations and evaluating progress.

Prior Authorization (PA) Audit Program

Objective

This report presents an introductory assessment of compliance with contractual requirements governing prior authorization PA processes for service requests reviewed by MCPs between Jan. 1, 2024 through Dec. 31, 2024. These requests were subsequently audited during CY2025.

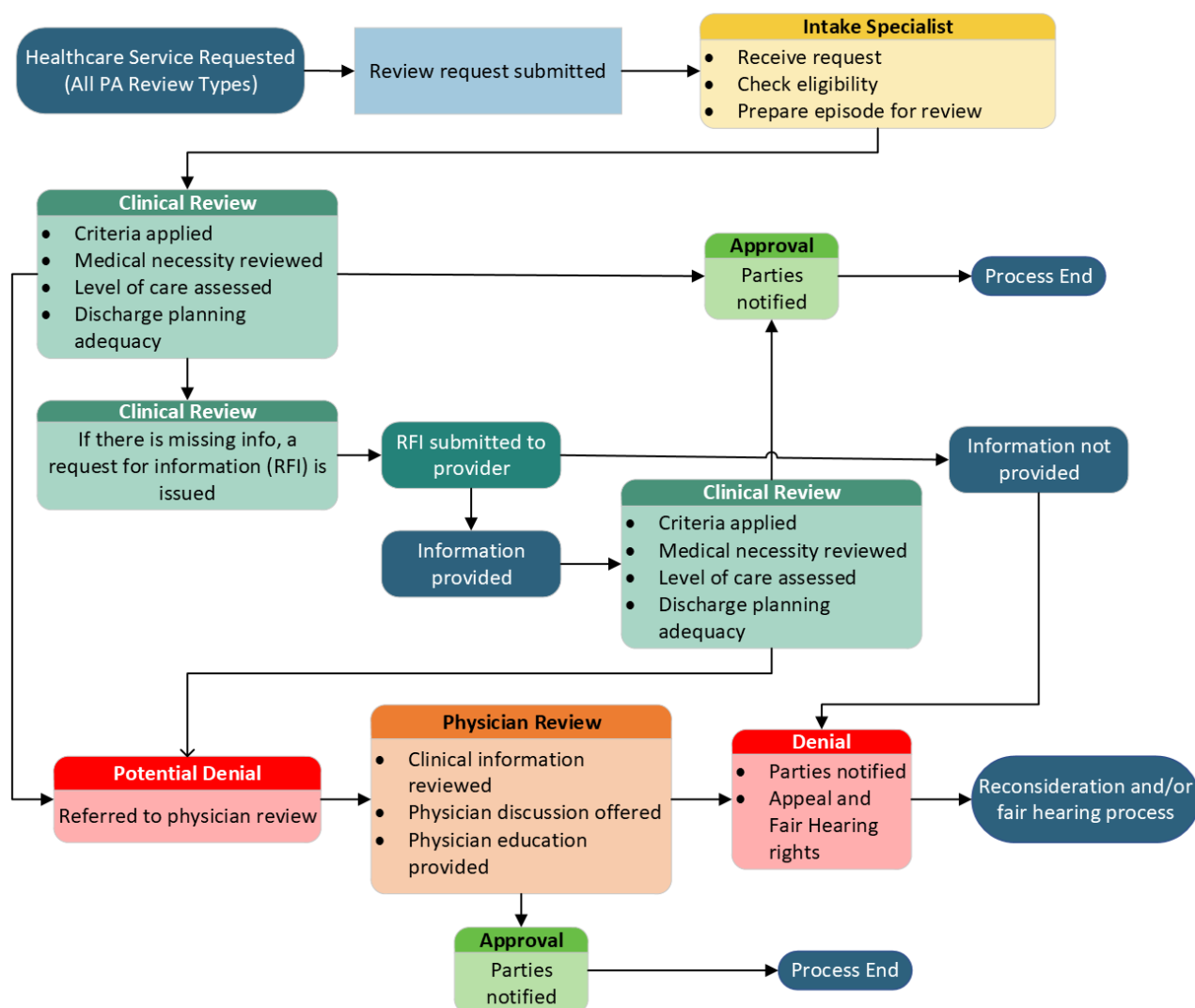
The purpose of this assessment is to establish a baseline for measuring MCP performance and identifying potential opportunities for program improvement and enhancement. The focus study was designed to systematically analyze underlying factors and key drivers affecting PA program outcomes, including operational challenges faced by MCPs. This optional EQR activity was conducted by Comagine Health in accordance with the *CMS EQR Protocol 9. Conducting Focus Studies of Health Care Quality*.

Overview

PA is a process where a patient's health care provider is required to obtain approval from the patient's health plan *before* providing health care services. Payers establish PA requirements to promote the delivery of safe, efficient and evidence-based care. It also helps to control costs and ensures accurate payments by verifying that the requested service is medically necessary, meets coverage criteria and aligns with standards of care. Per CMS, "a prior authorization is made up of two parts—a request from a provider and a decision by a payer."²⁶

An example of a standard review process for PA is depicted in Figure 30 below.

²⁶Centers for Medicaid & Medicare Services. Federal Register. (2024, February 8).
<https://www.federalregister.gov/d/2024-00895>

Figure 30. PA Standard Review Process.

In 2024, at the request of MHD, Comagine Health designed an audit program to assess the PA practices of its four contracted MCPs (HB, HSH, SMHK, UHC) against the PA requirements established in the MCP contract with MHD, Amendment #006, effective Oct. 1, 2023.

To ensure MCP compliance with PA requirements in its contract with MHD, Comagine Health completed an extensive review of documents and clinical records provided by the MCPs between April and October 2025. The comprehensive nature of the information collected during the audit enabled a thorough assessment centered on the quality and timeliness of PA denial determinations that prevented Medicaid beneficiary access to care. See [Appendix F: PA Audit Methodology](#) for more information about audit methodology.

Methodology

Audit Categories

The program was structured around two main audit categories: process and criteria. These categories were further subdivided into three focus areas:

Process Audit – an assessment of MCP adherence to timeliness standards (Table 119). The associated focus area and applicable contract sections include:

- **Focus Area 1:** Timeliness Standards – MHD Contract Sections 2.6.5(e7-8), 2.6.6(b1, b4-5)

Criteria Audit – an assessment of MCP compliance with documented practices related to medical necessity or clinical guideline selection and application, and their adherence to denial rationale documentation requirements (Table 120 and Table 121). The associated focus areas and applicable contract sections include:

- **Focus Area 2:** Selection and Application of Medical Necessity Criteria/Clinical Guidelines – MHD Contract Sections 2.6.5(e1-2, e8), 2.6.6(a1-2)
- **Focus Area 3:** Rationale in Denial Determination – MHD Contract Sections 2.6.5(e1, e3), 2.6.6(a3-4, a6-7)

Table 119. Process – Focus Area 1: Timeliness Standards.

Requirement	Description
T1	Timely request for additional information
T2	Timely issuance of denial determination
T3	Timely response to request for peer-to-peer (P2P) conversation/reconsideration

Table 120. Criteria – Focus Area 2: Selection and Application of Medical Necessity Criteria/Clinical Guidelines.

Requirement	Description
CSA1	Appropriate criteria set selection
CSA2	Appropriate criteria set application
CSA3	Appropriate request for additional information

Table 121. Criteria – Focus Area 3: Rationale in Denial Determination.

Requirement	Description
DRD1	Member-specific language
DRD2	Reference to medical necessity criteria/clinical guideline and first level reviewer findings
DRD3	Opinion of medical director
DRD4	Inclusion of impression after P2P conversation, where applicable

See [Appendix F: PA Audit Methodology](#) for more information about audit methodology.

Overall Results

Audits were conducted using review tools and guidelines developed by Comagine Health and approved by MHD. The audit assessed MCP adherence to timeliness standards, their appropriate selection and application of medical necessity criteria and/or clinical guidelines, and inclusion of member-specific rationale in denial determinations. The audit categories and focus areas are outlined in the previous section.

To offer a comprehensive evaluation of the program, Table 122 below displays audit results according to the focus area and MCP, in addition to an assessment at the program level (MO). The program level results consist of an average of the individual MCP results weighted by each MCP's proportion of the collective pool of denied reviews. For HB, HSH, SMHK and UHC, these proportions were 19%, 48%, 5% and 28%, respectively. Individual MCP results with performance below the 90% pass rate are highlighted in gray.

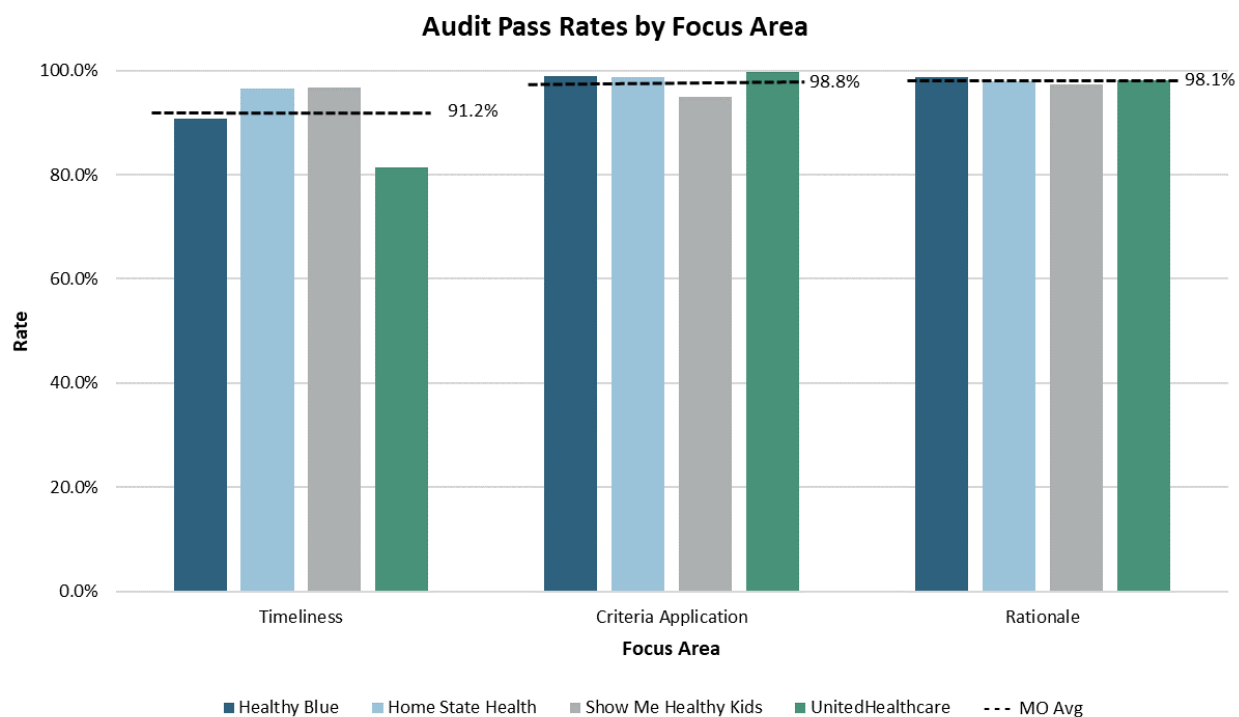
The audit's Pass/Not-Pass criteria elements were evaluated using the following thresholds:

- Pass: $\geq 90\%$
- Not-Pass: $< 90\%$

Table 122. Pass Percentages Focus Areas 1-3.

Compliance Measure	Description	HB	HSH	SMHK	UHC	MO
	Total Volume	370	378	332	375	1,455
Focus Area 1: Timeliness	Pass Volume	336	365	321	305	
	Not Pass Volume	34	13	11	70	
	Pass Percentage	90.8%	96.6%	96.7%	81.3%	91.2%
Focus Area 2: Selection and Application of Criteria/ Guidelines	Pass Volume	366	373	315	374	
	Not Pass Volume	4	5	17	1	
	Pass Percentage	98.9%	98.7%	94.9%	99.7%	98.8%
Focus Area 3: Rationale in Denial Determination	Pass Volume	365	370	323	368	
	Not Pass Volume	5	8	9	7	
	Pass Percentage	98.6%	97.9%	97.3%	98.1%	98.1%

Figure 31 below shows the pass percentages for each focus area by MCP in comparison to the program level (MO) result.

Figure 31: Audit Pass Rates by Focus Area.

Record Submission

During the PA Audit Program orientation sessions, all MCPs received detailed instructions outlining the record submission process, including timelines and formatting expectations. These preparatory steps were designed to ensure consistency and accuracy across submissions and to support MCPs in meeting audit requirements effectively.

The data points presented in the following subsections are not part of the formal audit evaluation. Instead, they offer valuable insight into the preparation phase of the audit, highlighting MCP responsiveness, understanding of the audit process and initial compliance efforts. This contextual information illustrates the operational readiness of the MCPs and may inform opportunities for future program refinement and support.

Audit Record Submission Summary

The record submission instructions provided to MCPs during program orientation outlined the requirements for timely and complete audit record submission.

Records that did not include all required documents were initially marked 'Incomplete' and MCPs were given the opportunity to submit missing documents. The volume of records submitted that were deemed complete on the initial submission and those deemed complete during subsequent submission (after Comagine Health requested more information) are noted in Table 123 below.

Table 123. Total Audit Record Request Volumes.

Record Submission Response	HB	HSH	SMHK	UHC
Complete Audit Records Received on <i>Initial</i> Submission	363	373	327	339
Complete Audit Records Received <i>After</i> Request for More Information	7	5	5	36
Total Number of Audit Records Requested	370	378	332	375

Observations

- All audit records were submitted within the timeframe outlined during MCP orientation. The consistent, timely delivery of complete documentation, along with the MCPs' responsiveness to requests for additional information, demonstrates strong operational efficiency, preparedness and accountability across plans. This high level of performance helped streamline the audit process by minimizing follow-up needs and reducing delays caused by incomplete submissions. Such a high degree of compliance not only lowers administrative burden but also improves the accuracy and reliability of data used for program evaluation. Reliable data enables more meaningful analysis, supports decision-making and strengthens the overall integrity of the audit findings.
- These outcomes also validate the effectiveness of the current program design. The ability to consistently collect complete and timely records suggests the program's structure, expectations and communication strategies are reliable, and supports scalability, indicating that the program can be expanded or adapted to future needs without compromising quality or efficiency.

Recommendations

The EQRO recommends that consistent record submission practices are maintained for future audits.

Audit Record Exclusion Summary

The audit focused on denied PA requests that limited beneficiary access to care. The primary data source was MHD's 'Prior – Authorizations and Denial Log,' which provided essential information for record selection. However, the report lacked several key data elements needed to automate the process of isolating service requests within the defined focus area. As a result, the audit team could not rely solely on system-generated indicators to determine which records met the inclusion criteria. To address this limitation, MCPs received guidance during the PA audit program orientation sessions. These sessions offered detailed instructions on manually identifying and flagging records that did not meet the established inclusion criteria and required exclusion from the audit.

While the need for manual identification introduced additional steps for MCPs, it also highlighted the importance of clear communication and training in maintaining audit integrity. These findings helped to recognize potential future enhancements to data systems and audit workflows, with the goal of improving automation capabilities and reducing manual burden.

Table 124 below summarizes the reasons for audit record exclusions, by volume, for each MCP. Removing these records ensured the audit remained focused on denied service requests that restricted beneficiary access to care.

Table 124. Audit Record Exclusion Volumes.

Audit Record Exclusion Reason	HB	HSH	SMHK	UHC
Emergent Hospital Admission	32	1	0	4
Concurrent Review	0	41	136	355
Retrospective Review	21	11	14	1
Partial Approval/Denial	17	17	86	30
Approved after Reconsideration or P2P	10	1	1	59
Appeal in Progress	0	1	0	0
Modified on Appeal	0	0	0	2
Overtaken on Appeal	3	3	3	15
Upheld on Appeal	9	17	19	13
Other	1	0	0	4
Duplicate Request	0	0	0	27
Totals	93	92	259	510

Observations

All MCPs exhibited a solid grasp of the exclusion criteria as evidenced in the table above. This foundational understanding is critical to ensuring consistency and accuracy in medical record submissions and supports the integrity of the audit process. Despite this overall competency, there were notable instances where medical records were initially submitted in error. These errors required resubmission after confirmation that inclusion criteria were not satisfied. Such occurrences suggest that while the criteria are generally well understood, there were gaps in internal review processes or documentation verification practices prior to submission.

The number of resubmissions due to this issue varied across MCPs with HSH and UHC having the highest number of resubmissions:

- HB – 5 resubmissions
- HSH – 14 resubmissions
- SMHK – 3 resubmissions
- UHC – 19 resubmissions

It is also important to note that there were two exclusion reasons added during the audit:

‘Other’ to capture:

- An administrative approval due to a missed turnaround time by HB
- UHC’s delegate association with Children’s Mercy Primary Care Network (PCN)

‘Duplicate Request’:

- UHC cases were randomly selected more than once due to their unique practice of assigning multiple PA numbers to requests involving more than one service code.

Recommendations

The EQRO recommends the following to improve practices related to audit record exclusions:

- **Address process improvement and system enhancement opportunities:** MCPs may benefit from targeted technical assistance or process refinement, particularly those with higher

resubmission rates. Addressing this issue can further improve submission accuracy, reduce administrative burden, and enhance overall efficiency during future audit cycles.

- **Address the identified limitations in the existing ‘Prior – Authorizations and Denial Log’ report template that impacted the audit team’s ability to fully automate the exclusion identification process.**
 - The report lacked several key data elements necessary for system-driven filtering; therefore, MCPs were required to manually identify records that needed to be excluded. During the PA audit cycle, in support of audit program improvement, Comagine Health provided MHD with recommendations for report enhancements not only for the ‘Prior - Authorizations and Denial Log’ but also two others:
 - ‘Grievance and Appeal Report: Member Issue Log (Closed)’
 - ‘Grievance and Appeal Report: Member Issue Log (Open)’

The proposed modifications aim to improve data usability, streamline audit workflows and reduce reliance on manual interventions. MHD has reviewed and accepted these recommendations, with implementation anticipated in 2026. Once adopted, these enhancements are expected to significantly strengthen the audit program infrastructure and support more scalable data-driven oversight of MCP PA practices.

Prior Authorization Decision Timeline Impact Summary

The type of PA, routine or urgent, and the associated workflows, such as request for additional information and peer-to-peer (P2P) conversations, directly influence the amount of time within which MCPs must render a PA determination. Urgent requests typically require expedited review, while routine requests allow for more extended evaluation periods. The timeframes are further shaped by the need for supplemental documentation or clinical dialogue between MCPs and providers.

These dynamics supply valuable insight into provider submission behaviors. For instance, the frequency and timeliness of provider responses to requests for additional information can impact the overall efficiency of the PA process. Similarly, provider participation in P2P conversations may reflect their engagement in clinical justification and willingness to collaborate on care decisions.

There are no federal or industry standards for PA types or rates related to requests for more information and P2P discussions. However, understanding these patterns helps identify opportunities to improve communication, streamline workflows and enhance the overall responsiveness of the PA system. It also informs future audit program design by highlighting where additional guidance or support may be needed to ensure timely and accurate decision-making across varying PA scenarios.

Table 125, Table 126 and Table 127 below summarize these patterns according to MCP, PA types and processes.

Table 125. PA Types.

PA Types	HB	HSH	SMHK	UHC
Routine	369	377	332	364
Urgent	1	1	0	11
Totals	370	378	332	375

Table 126. PA Processes – Request for Information.

PA Process Step	HB	HSH	SMHK	UHC
Request for Information	1	110	113	177
Information Received	0	13	29	80
Request for Information Response Rate	0%	11.8%	25.7%	45.2%

Table 127. PA Processes – P2P Discussion Offer.

PA Process Step	HB	HSH	SMHK	UHC
P2P Discussion Offers	254	206	217	189
P2P Discussion Offer Rate	68.6%	54.5%	65.4%	50.4%
P2P Discussions Completed	11	18	10	27
P2P Discussion Completion Rate	4.3%	8.7%	4.6%	14.3%

Observations

- Most service requests were designated as ‘routine.’ Table 125 above shows the number of ‘urgent’ and ‘routine’ requests included in the audit for each MCP.
- When there is insufficient information upon which to render a utilization review determination, a request for additional documentation may be appropriate.
- Table 126 shows a substantial practice variation when comparing HB to the other MCPs. A contributing factor may be the automated workflow of an HB PA vendor, which seemingly bypasses the step of requesting additional information by substituting the requesting provider’s attestation that all available clinical information was submitted.
- UHC achieved the highest response rate to requests for information, with 45.2% of such requests resulting in additional records being provided.
- MCPs offer pre-determination P2P discussions at varied rates, as displayed in Table 127, with data showing a range from a low of 50.4% to a high of 68.6%. P2P discussions, when offered, were completed at a rate of less than 15% for all MCPs.

Recommendations

The EQRO recommends the following to improve outcomes related to PA decision timelines and associated workflows.

- **Evaluate outreach practices:** The identification of only one request for additional information suggests that HB may benefit from a closer evaluation of its current outreach practices. Understanding the underlying reasons for limited engagement in the practice of requesting supplemental documentation could reveal process gaps or training needs. Targeted staff education in this area may help reinforce the importance of proactive outreach and ensure that all relevant clinical information is considered during the review process.
- **Optimize communication channels:** For MCPs utilizing care management software systems, there is an opportunity to enhance provider communication by issuing requests for information through a provider portal rather than relying on fax or telephone. Leveraging electronic platforms can improve delivery reliability, reduce turnaround time, and increase the likelihood that providers receive and respond promptly to requests for additional information. This

approach aligns with broader efforts to modernize communication workflows and improve utilization review process efficiency.

- **Strengthen P2P engagement:** P2P conversations are a critical component of the utilization review process, offering MCPs a valuable opportunity to obtain member-specific clinical insights that may not have been included in the initial service authorization request. These discussions also serve as educational touchpoints for providers, fostering collaboration and shared understanding. MCPs should consider placing greater emphasis on consistently offering P2P discussions and actively promoting their value. Given the current low completion rates, MCPs are encouraged to investigate root causes, such as scheduling barriers or provider lack of awareness, and explore strategies to increase engagement and participation in these conversations.

Prior Authorization Decision Timeliness Results

Managed Care Contract Section 2.6.5 Prior Authorization specifies the following minimum requirements:

- Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider, and
- Approval or denial shall be provided within 36 hours, which shall include one business day of obtaining all necessary information for routine services, and
- The health plan shall not exceed 14 calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the health plan justifies a need for additional information and shows how the extension is in the enrollee's best interest.

The type of PA, routine or urgent, and related process steps, such as a request for additional information, influence the timeframe within which MCPs must issue a PA determination. For each audited record, the elapsed time from PA request submission until communication of the decision was collected. When observed timeframes were less than one hour or less than one calendar day, the minimum timeframe captured for reporting purposes was one hour (when no additional information was requested), and one calendar day (when such a request occurred).

Table 128 below summarizes the average completion time, by MCP, when the PA *did not* involve a request for additional information. The completion time is expressed in hours and rounded to the nearest whole hour.

Table 128. Timeliness – Average Elapsed Time, in Hours, From Request Submission to Communication of Decision – Without a Request for Additional Information.

Timeliness Variable	HB	HSH	SMHK	UHC
Routine – within 36 hours	31	23	28	53
Urgent – within 24 hours	5	1	NA	6

Observations

- Routine cases, *without* requests for additional information, were managed within the required 36-hour timeframe for HB, HSH and SMHK.
- Urgent cases, *without* requests for additional information, were infrequent: HB – 1; HSH – 1; SMHK – 0; UHC – 7. All MCPs processed these cases within the contracted 24-hour timeframe.

Recommendations

The EQRO recommends the following to improve outcomes related to PA decision timeliness results without a request for additional information.

- **Address timeliness deficiency:** UHC's average response time for routine cases, *without* requests for additional information, exceeded the 36-hour requirement. Contributing factors lie in two separate segments of the utilization review process:
 - Delay from the initial clinical reviewer's referral to a medical director and the subsequent rendering of the medical director's determination, and
 - Elapsed time between recording the medical director's decision and communicating the determination to the requesting provider.

To bring timeliness into compliance, UHC would benefit from more closely examining these workflow components to identify and address root cause(s) of the delay.

Table 129 displays the average completion time, by MCP, when the PA *did* involve a request for additional information. The completion time is expressed in calendar days and rounded to the nearest whole day.

Table 129. Timeliness – Average Elapsed Time, in Calendar Days, From Request Submission to Communication of Decision – With a Request for Additional Information.

Timeliness Variable	HB	HSH	SMHK	UHC
Routine – within 14 calendar days	12	7	7	5
Urgent – within 14 calendar days	NA	NA	NA	2

Observations

- Routine cases, *with* requests for additional information, were completed in a timely fashion by all MCPs.
- Urgent cases, *with* requests for additional information, were infrequent: HB – 0; HSH – 0; SMHK – 0; UHC - 4. Assuming that extended timeframes are applicable to cases with an urgent designation, all MCPs processed these cases within the contracted parameters.
- Requests for additional information influence the timeframes within which MCPs must issue PA determinations. Evidence suggests that some MCPs:
 - Utilize technology to automate these requests when PA submissions are received electronically.
 - Automatically generate information requests when the PA process begins telephonically.

These practices may unintentionally distort timeliness metrics.

Recommendations

The EQRO recommends the following to improve outcomes related to PA decision timeliness results with a request for additional information.

- MCPs are responsible for determining whether a service request meets the criteria for urgency based on the member's clinical condition. If additional information is required for an urgent request, the MCP should promptly contact the requesting provider and make every effort to obtain the necessary details without delay; however, the MCP must still comply with the established urgent decision timeframe. MCPs would benefit from MHD's guidance related to the applicability of extended timeframes for urgent requests.

- Requests for information should not be initiated solely based on the PA submission method (portal or telephone). Best practice is to issue these requests only after an initial review confirms that additional documentation is truly necessary. When implementing automation, it is essential to maintain accurate and transparent timeliness metrics. Safeguards, such as monitoring for unintended impacts on compliance standards, help preserve integrity while optimizing workflow. MHD should consider further investigation into these practices. To comprehensively assess the impact, this evaluation could be formally incorporated into a future audit, enabling MHD to address any identified compliance or operational risks associated with automated requests for information in PA workflows.

Prior Authorization Audit Results

PA has an important place in the health care system; however, the process for obtaining PA can present challenges. As noted by CMS in its final rule, “dissimilar payer policies, inconsistent use of electronic standards, and other technical barriers have created provider workflow challenges and an environment in which the PA process is a primary source of burden for both providers and payers, a major source of burnout for providers, and can create a health risk for patients if inefficiencies in the process cause delays in medically necessary care.”²⁷ More states are auditing their PA programs to ensure that they are serving their intended purpose and not delaying or denying medically necessary care to beneficiaries.

In alignment with MHD’s contractual requirements, Comagine Health’s PA audit process was designed to closely examine related MCP procedures, recognize best practice examples, and identify potential improvement opportunities. See the [2025 Prior Authorization Audit Program Report](#) for additional details on the audit assessment questions.

Program Level Audit Results

The audit assessed MCP adherence to timeliness standards, their appropriate selection and application of medical necessity criteria and/or clinical guidelines, and inclusion of member-specific rationale in denial determinations. The audit category and focus areas are as follows:

- **Process – Focus Area 1:** Timeliness Standards
- **Criteria – Focus Area 2:** Selection and Application of Medical Necessity Criteria/Clinical Guidelines
- **Criteria – Focus Area 3:** Rationale in Denial Determination

The audit’s Pass/Not-Pass criteria elements were evaluated using the following thresholds:

- Pass: $\geq 90\%$
- Not-Pass: $< 90\%$

Table 130 below shows the Pass/Not-Pass rates by focus area at the PA Program Level.

²⁷ Centers for Medicaid & Medicare Services. Federal Register. (2024, February 8). <https://www.federalregister.gov/d/2024-00895>

Table 130. Pass/Not-Pass Rates by Focus Area – PA Program Level (MO).

Pass/Not-Pass Rates	Process Focus Area 1	Criteria Focus Area 2	Criteria Focus Area 3
Pass Volume	1,327	1,428	1,426
Not-Pass Volume	128	27	29
Total Volume	1,455	1,455	1,455
Pass Percentage	91.2%	98.1%	98.0%

All MCPs met the standards in focus areas 2 and 3; however, not all MCPs achieved the required thresholds in focus area 1.

- **Focus Area 1 (91.2%)**
 - Pass Percentage – Three out of the four MCPs met the threshold.
- **Focus Area 2 (98.1%)**
 - Pass Percentage – All of the MCPs met the threshold.
- **Focus Area 3 (98.0%)**
 - Pass Percentage – All of the MCPs met the threshold.

The following sections provide additional program level insights into the PA process, highlighting strengths, weaknesses/opportunities for improvement, and recommendations to MHD.

Strengths are defined as anything that scored at or above 90% (Pass). Weaknesses/opportunities for improvement are included for anything that scored below 90% (Not Pass). Recommendations are provided to MHD for all identified weaknesses and opportunities for improvement.

Focus Area 1: Timeliness Standards

Strengths

- HB, HSH and SMHK met timeliness standards with pass rates of 90.8%, 96.6% and 96.7%, respectively.
- UHC issues status updates (pending clinical review, pending medical director review) to requesting providers throughout the review process.
- Routine outbound calls to providers to communicate review determinations was consistently observed for HSH and is considered a best practice example of HSH's commitment to timely and effective notification.

Weaknesses/Opportunities for Improvement

- UHC did not meet timeliness standards, with a pass rate of 81.3%.
- Section 2.6.5 of the Managed Care Contract is not in alignment with CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), effective Jan. 1, 2026.
- Timeliness should be measured from the date and time the MCP receives a PA request to the date and time the review determination is *communicated* to the requesting provider. Although not a quantifiable finding, the audit identified a recurring pattern: the 'Decision Date' and 'Decision Time' reported by MCPs in the 'Prior - Authorizations and Denial Log' more closely aligned with the MCP medical director *decision* timestamp rather than the date

and time the review determination was *communicated* to the requesting provider. This discrepancy suggests a data mapping error, likely stemming from unclear reporting parameters, within MCP care management systems.

Recommendations

The EQRO recommends the following to improve outcomes related to timeliness standards:

- Address timeliness improvement opportunities:
 - Among the 34 cases that did not meet the timeliness standard for HB, a delay was observed between the denial determination and the communication of that decision to the requesting provider. This highlights an opportunity for HB to review their workflow, identify the root cause of the delay and implement improvements to ensure the pass rate continues to meet or exceed the 90% requirement.
 - There were 70 cases that did not meet the timeliness standard for UHC. Contributing factors lie in two separate segments of the utilization review process: 1. Delay from the initial clinical reviewer's referral to a medical director and the subsequent rendering of the medical director's determination, and 2. Elapsed time between recording the medical director's decision and communicating the determination to the requesting provider. These findings highlight an opportunity for UHC to review their workflows, identify the root cause(s) of delays and implement improvements to ensure the pass rate consistently meets or exceeds the 90% requirement moving forward.
- Review and amend contract provisions to ensure alignment with the accelerated decision timelines established by the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), effective Jan. 1, 2026. Currently, Section 2.6.5 of the Managed Care Contract permits up to 28 days for an MCP to issue a PA determination when extensions are applied. Under the new rule (42 CFR § 438.210), the maximum allowable timeframe in similar circumstances is 21 days. Timely reconciliation of this discrepancy is essential to safeguard MHD and MCPs from compliance vulnerabilities.
- Provide technical assistance for data mapping: MCPs would benefit from technical assistance from MHD to ensure that data elements in their care management software system are properly mapped to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report. Under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F),²⁸ payers must begin publicly posting PA metrics. The following metrics from the previous calendar year must be published:
 - Percentage approved
 - Percentage denied
 - Percentage approved after appeal
 - Average (mean) and median response times

Clear guidance from MHD on data mapping will help MCPs ensure that PA data is reported in full compliance with MHD instructions, and that public reporting is properly aligned with CMS requirements.

²⁸ Centers for Medicare & Medicaid Services. Federal Register (2024, February 8). *Federal Register*, 89(27), 12345–12456. <https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability>

Focus Area 2: Selection and Application of Medical Necessity Criteria/Clinical Guidelines

Strengths

- HB, HSH, SMHK and UHC all performed well in this area, with pass rates of 98.9%, 98.7%, 94.9% and 99.7%, respectively.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines, in addition to applicable medical necessity criteria, are clearly being incorporated into the reviews performed by all MCPs.
- UHC's care management system has the ability for users to be assigned based upon competency and/or work schedules. This was evident in notes stating, 'Case rejected reason: Competency change' and 'Case rejected reason: End of shift.' This functionality optimizes UHC's capability to operate with a staffing model that ensures reviews are assigned according to work schedules and conducted by professionals with direct experience in specialty areas.
- The following are viewed as best practice examples of staffing model optimization:
 - HB – Initial clinical review for physical therapy services was routinely performed by a physical therapist, and
 - HSH and SMHK – Initial clinical review for physical therapy, occupational therapy and speech therapy services is managed by licensed professionals – physical therapists (PT), occupational therapists (OT) and speech therapists (ST) – based upon their respective disciplines.

Weaknesses/Opportunities for Improvement

- There is inconsistency in the handling of adverse determinations for seemingly administrative reasons (i.e. non-covered service/benefit exclusion, late notification, member ineligibility). Some were reviewed by the MCP medical director, and others were processed without MCP medical director involvement.
- HSH and SMHK medical necessity denial determinations for therapies (PT, OT, ST) are not rendered by MCP medical directors.

Recommendations

The EQRO recommends the following to improve outcomes related to the selection and application of medical necessity criteria/clinical guidelines.

- **Establish a standardized approach to administrative denials:** Currently, there is no uniform process across MCPs for managing administrative denials, which may lead to inconsistencies in how these cases are handled and communicated. Developing a standardized approach would help to ensure fairness, transparency and regulatory alignment. MCPs would benefit from MHD's guidance in defining clear protocols and expectations for administrative denial management, including documentation standards, workflows and communication practices.
- **Clarify expectations related to medical director denial determination oversight:** HSH and SMHK medical necessity denial determinations for outpatient therapies are made by licensed professionals. PT, OT and ST, based on their respective clinical experience. While discipline-specific input is valuable, denials should not be issued without review and support from the MCP medical director to ensure consistency with broader clinical standards and regulatory requirements. Any exceptions to this protocol should be reviewed with MHD to confirm compliance and maintain alignment across plans. Additional information can be found in MHD Provider Bulletin, Volume 47 Number 17, dated Aug. 20, 2024.

Focus Area 3: Rationale in Denial Determination

Strengths

- HB, HSH, SMHK and UHC all performed well in this area, with pass rates of 98.6%, 97.9%, 97.3% and 98.1%, respectively.
- Medical necessity denial reason deficiencies were infrequent. Findings were generally related to:
 - Incorrect criteria/guideline selection and/or application, or
 - Rationale that included the need for conservative care with no suggestion to verify benefits, or
 - The misstatement of a suggested alternative service, or
 - Language that did not accurately reflect the member's clinical picture, suggesting that portions of the medical record may not have been considered

Weaknesses/Opportunities for Improvement

- Post-decision activities warrant additional evaluation:
 - Vendors may not be delegated to generate correspondence following reconsideration, and it was unclear how MCPs managed that workflow.
 - The dismissal of appeal requests due to the submitting party's failure to include a required 'Appointment of Representation' or 'Authorized Representative Designation' form was observed. Evidence of an attempt to obtain missing documentation was not always visible and may demonstrate an opportunity for MCPs to align more closely with MHD Contract Section 2.16.6(h) which expresses that the health plan shall give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal.

Recommendations

The EQRO recommends the following to improve outcomes related to rationale in denial determinations:

- The Office of Inspector General (OIG) released a 2023 report evaluating whether Medicaid Managed Care enrollees receive medically necessary health care services and examining the adequacy of state oversight of prior authorization denials.²⁹ That report highlighted the following key findings and recommendations for MHD's consideration.
 - OIG key findings were:
 - High Denial Rates – Some MCPs had denial rates more than 25%.
 - Limited State Oversight – Most states do not routinely review the appropriateness of PA denials. Oversight processes are often insufficient and vary widely.
 - Limited Access to External Medical Reviews – Few states offer automatic external medical reviews for upheld denials, leaving enrollees with limited recourse.

²⁹ U.S. Department of Health and Human Services, Office of Inspector General. (2023, July). *High rates of prior authorization denials by some plans and limited state oversight raise concerns about access to care in Medicaid managed care* (Report No. OEI-09-19-00350). <https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicaid-managed-care/>

- OIG recommendations to CMS included:
 - Regularly review samples of MCP PA denials
 - Collect and analyze data on PA decisions
 - Issue guidance on using this data for oversight
 - Implement automatic external medical reviews for upheld denials
 - Identify and address MCPs with potentially inappropriate denial patterns
- Post-decision activities were not incorporated into this audit. In partnership with MHD, Comagine Health will develop an audit tool for the next cycle that specifically evaluates MCP reconsideration and appeal workflows. This approach aims to demonstrate MHD's responsiveness to the OIG recommendations outlined above.

Additional Program Level Audit Observations

Pursuant to MHD Contract Sections 2.14.3(h), 2.15.6(f1-4), and 2.65(e), prior authorization decisions must be communicated to both members and providers. Member notice templates are subject to review and approval, as directed, by the state agency. The audit identified inconsistencies in the content and structure of denial notices across the MCPs, which may result in confusion for members and providers and increase the risk of non-compliance.

Because Medicaid denial letter templates vary by state and individual circumstances, a single best-practice standard does not exist. Table 131 below presents the elements commonly included in these communications. Adopting a consistent approach to incorporating this content into denial correspondence fosters transparency, promotes regulatory compliance and ensures that letters are clear, comprehensive and actionable, furnishing members and providers with the information necessary to fully understand the determination and pursue appropriate next steps.

Table 131. Correspondence Elements.

Element	Description
E1	PA/Case Identification number
E2	Service(s) requested
E3	Service(s) denied
E4	Clearly documented denial reason(s), including regulatory guideline and/or medical necessity criteria citation
E5	P2P offer
E6	Appeal information and instructions
E7	Language describing member's right to continued health benefits pending appeal resolution
E8	Grievance information and instructions
E9	State fair hearing information and instructions

A total of 1,455 cases were reviewed during this audit; 123 were administrative denials and 1,332 were medical necessity denials.

Table 132 and Table 133 below provide an aggregate summary of the current practices related to the inclusion of these nine elements in MCP member and provider denial correspondence for administrative and medical necessity denials.

Table 132. Aggregate Member Denial Results by Correspondence Element and Denial Type.

Correspondence Element	Administrative		Medical Necessity	
	Element Included		Element Included	
E1 PA Number	29	23.6%	763	57.3%
E2 Service(s) requested	107	87.0%	1,332	100%
E3 Service(s) denied	108	87.8%	1,332	100%
E4 Denial reason(s)	104	84.6%	1,309	98.3%
E5 P2P Offer	36	29.3%	830	62.3%
E6 Appeal Instructions	108	87.8%	1,331	99.9%
E7 Member's Rights	104	84.6%	1,331	99.9%
E8 Grievance Instructions	95	77.2%	1,271	95.4%
E9 State Fair Hearing Instructions	107	87.0%	1,331	99.9%

Observations

- The PA number, commonly referred to as a case identification number or reference number when associated with denial determinations, is a unique identifier assigned to a case upon receipt of a PA request from a provider. This number plays a critical role throughout the utilization review process by enabling accurate documentation, facilitating clear and efficient communication among members, providers and MCPs, and supporting streamlined auditing. Inclusion of this element ensures that all related documentation, correspondence and determinations are properly linked to the correct PA request, reducing administrative errors, and promoting compliance with regulatory requirements. The PA number is often required for claim submissions, appeals and other post-service processes, making it an essential component for maintaining continuity of care and accountability within the health care delivery system. MHD Contract Section 2.6.5(e3) supports the assignment of a PA number. During this audit it was observed that the MCPs do not consistently include the PA number in their member correspondence.
- There were 15 administrative denial cases where MCPs did not include member denial correspondence in their audit submissions. Consequently, the 'Administrative' data shown in the table above may moderately underrepresent the actual count that would have been reported if all cases had included the required correspondence. This was particularly impactful for the following:
 - Service(s) requested
 - Service(s) denied
 - Denial reason(s)
 - Appeal instructions
 - Member rights
 - Grievance instructions
 - State Fair Hearing instructions
- P2P offers were included in member correspondence at a low frequency for both administrative and medical necessity denials. While omitting P2P language in administrative denial letters may be justifiable, its inclusion in medical necessity denial correspondence is highly beneficial from a transparency and member engagement perspective. Extending this offer ensures members and providers are aware of an opportunity for the requesting provider to discuss the decision

directly with the MCP medical director. This process step can help clarify medical rationale, reduce misunderstandings and potentially expedite resolution. One MCP demonstrates best practice by including language such as: “Does your doctor want to talk to someone? Your provider can talk to the individual(s) who made the decision by calling...” This approach promotes collaboration, supports continuity of care, and reinforces trust between providers, members and MCPs. Expanding the use of P2P offers in medical necessity denials could significantly improve member experience and provider satisfaction while aligning with principles of transparency and fairness.

Table 133. Aggregate Provider Denial Results by Correspondence Element and Denial Type.

Correspondence Element	Administrative		Medical Necessity	
	Element Included		Element Included	
E1 PA Number	66	53.7%	915	68.7%
E2 Service(s) requested	118	95.9%	1,330	99.8%
E3 Service(s) denied	119	96.7%	1,330	99.8%
E4 Denial reason(s)	115	93.5%	1,307	98.1%
E5 P2P Offer	72	58.5%	1,315	98.7%
E6 Appeal Instructions	117	95.1%	1,329	99.8%
E7 Member's Rights	101	82.1%	1,329	99.8%
E8 Grievance Instructions	94	76.4%	821	61.6%
E9 State Fair Hearing Instructions	104	84.6%	1,329	99.8%

Observations

- As with member correspondence (see observations in the section above), the PA number serves a critical purpose and should be included in all provider correspondence.
- There were four administrative denial cases and two medical necessity cases where the MCPs did not include provider denial correspondence in their audit submissions. Consequently, the ‘Administrative’ and ‘Medical Necessity’ data shown in the table above may slightly underrepresent the actual counts that would have been reported if all cases had included the required correspondence.
- Similarly to what was observed with member correspondence, P2P offers are not consistently included in provider letters related to administrative denials. This omission may be appropriate.
- These results suggest that MCPs lack clarity on the requirement to include member rights, grievance instructions and state fair hearing instructions in administrative denial letters. Similarly, grievance instructions are not consistently incorporated into medical necessity denial correspondence sent to providers.

Strengths

- Several elements are routinely incorporated into member and denial correspondence.
- Some MCPs frequently shared correspondence with primary care providers (PCPs) in addition to the requesting and servicing providers. This is an excellent means by which to ensure PCP awareness and facilitate the effective coordination of care.

Weaknesses/Opportunities for Improvement

- MCPs demonstrated inconsistency in their administrative denial workflows, including the assignment of denial reasons. This lack of uniformity creates variability in how PA requests are processed and communicated. Without a standardized framework, denials may be misclassified or insufficiently explained, leading to confusion for members and providers, reducing transparency, and weakening the effectiveness of appeal and grievance processes.
- Denial correspondence issued by MCPs is not standardized in either format or content. This lack of uniformity introduces significant risks, including non-compliance with contractual and regulatory requirements, diminished clarity for members and providers and potential delays in care. Inconsistent communication may also result in confusion regarding next steps, missed appeal deadlines and an increase in grievances.
- Requests for information are frequently issued without clear response timeframes. When deadlines are undefined, providers may not prioritize responses, leading to administrative inefficiencies, delays in PA decisions and potential barriers to timely access to medically necessary services for members.
- Data elements (i.e. PA Number, Member ID/Department Client Number [DCN]) abstracted from medical records frequently differed from those transmitted to MHD on the 'Prior - Authorizations and Denial Log.' This discrepancy suggests a data mapping issue within the MCP care management systems.

Recommendations

The EQRO recommends the following to improve outcomes related to correspondence.

- **The MCPs would benefit from clear MHD-issued guidance to establish standardized criteria for what constitutes an administrative denial.** This guidance should include a comprehensive list of scenarios that qualify as administrative denials, along with examples and documentation requirements. Establishing uniform standards will promote consistency across MCPs, reduce ambiguity in denial classifications, and ensure compliance with contractual and regulatory expectations. Additionally, standardized criteria will enhance transparency for providers and members, supporting fair and accurate decision-making processes.
- **The MCPs should collaborate with MHD to review and revise the templates currently used for issuing PA denial notices to members and providers.** With standardized templates, MCPs will achieve greater uniformity in denial communications, strengthen compliance with regulatory requirements, and improve transparency and clarity for members and providers. This collaborative effort should ensure that all templates:
 - Adhere to contractual and regulatory obligations.
 - Incorporate correspondence elements that are tailored appropriately for administrative denials and medical necessity denials. Refer to the MHD contract-specifically section 2.16 Member Grievance System Requirements, for the related definitions.
 - Enhance clarity and transparency, enabling members and providers to fully understand the PA determination and the next steps available.
- **Evaluate MCP practices for issuing written requests for additional information.** Clearly articulating and communicating response timeframes is critical, not only to ensure compliance with utilization review decision timeliness requirements, but also to uphold provider confidence and safeguard continuity of care for members.

- **MCPs would benefit from targeted technical assistance from MHD to ensure accurate mapping of care management software system data elements to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report.** Proper alignment of these data fields is critical for maintaining data integrity, enabling accurate reporting and supporting meaningful analysis. Collaborative efforts to refine the mapping process could enhance audit efficiency and reduce reporting discrepancies. With recent updates to report specifications, this is an ideal opportunity to bring MCPs into full alignment with MHD's reporting requirements.
- **MHD should collaborate with MCPs to enhance care coordination through information sharing. Sharing PA determinations with the members' PCPs is widely recognized as a best practice that supports effective care coordination and contributes to improved member outcomes.** Expanding this practice across MCPs would strengthen communication between care teams, reduce duplication of services and ensure that PCPs are fully informed when making clinical decisions. Broader implementation could yield significant benefits for both members and providers.

Individual MCP Audit Results



Comagine Health completed a comprehensive review of audit records provided by the MCPs. The information gathered helped assess the quality and timeliness of denial determinations issued to Medicaid beneficiaries and their providers.

Strengths are defined as thresholds that scored at or above 90% (Pass).

Weaknesses/opportunities for improvement are included for any threshold that is below 90% (Not Pass). Recommendations are provided for all identified weaknesses and opportunities for improvement and will be shared with MHD to guide further actions for MCPs.

The audit assessed MCP adherence to timeliness standards, their appropriate selection and application of medical necessity criteria and/or clinical guidelines, and inclusion of member-centric rationale in denial determinations. The audit category and focus areas are as follows:

- **Process – Focus Area 1:** Timeliness Standards
- **Criteria – Focus Area 2:** Selection and Application of Medical Necessity Criteria/Clinical Guidelines
- **Criteria – Focus Area 3:** Rationale in Denial Determination

Healthy Blue

The overall pass score for HB was 96.1%. Table 134 below shows the Pass/Not-Pass rates by focus area for HB.

Table 134. HB Audit Results by Focus Area.

Pass/Not-Pass Rates	Process Focus Area 1	Criteria Focus Area 2	Criteria Focus Area 3
Pass Volume	336	366	365
Not-Pass Volume	34	4	5
Total Volume	370	370	370
Pass Percentage	90.8%	98.9%	98.6%

Strengths

- EPSDT guidelines, in addition to applicable medical necessity criteria, are clearly being incorporated into HB's utilization review process.
- HB correspondence was frequently shared with PCPs in addition to the requesting and servicing providers. This is an excellent means by which to ensure PCP awareness and effective coordination of care.
- HB's initial clinical review for physical therapy PA service requests was routinely performed by a PT. This serves as a best practice example of an optimized staffing model centered on ensuring that reviews are conducted by professionals with direct experience in a specialty area.
- HB's pass percentages for timeliness, selection and application of medical necessity criteria/clinical guidelines, and rationale in denial determination were 90.8%, 98.9% and 98.6%, respectively.

Weaknesses/Opportunities for Improvement

- HB's correspondence elements (i.e. PA Number, Member ID/DCN) noted in the medical record frequently differed from those transmitted to MHD on the 'Prior - Authorizations and Denial Log.'
- HB does not demonstrate a standardized approach to managing requests involving more than one service code. Some cases show that multiple denial letters, one for each service code, were issued. Others have a single denial letter covering all requested codes.
- For HB cases that have the same provider listed as the requesting and servicing provider, correspondence is transmitted multiple times.
- The mode of transmission for HB correspondence is primarily fax. There does not appear to be a standardized process for addressing failed faxes.
- When duplicate requests for PA are submitted, the HB denial rationale conveys that the service was approved; however, there is no reference made to the specific approval information (i.e., PA Number, approved date(s) of service) associated with the original approval.
- Inconsistency in the handling of HB's adverse determinations for seemingly administrative reasons (i.e. non-covered service/benefit exclusion, late notification, member ineligibility) was noted. Some were reviewed by the MCP medical director, and others were processed without MCP medical director involvement.
- When there is insufficient information upon which to base a utilization review determination, a request for additional information may be appropriate. This process was rarely observed during the HB audit. One contributing factor may be the automated workflow employed by an HB vendor, which seemingly bypasses the step of requesting additional information; instead, the process relies on the requesting provider's attestation that all necessary clinical information was submitted.
- Provider misuse of the 'Alternative Therapies for Chronic Pain Management' and 'Authorization Exceptions Request' forms was noted.
- The dismissal of HB appeal requests due to the submitting party's failure to include a required 'Appointment of Representation' form was observed without evidence that this missing information was formally requested.

- A standardized process for managing HB's post-decision submission of clinical documentation is not evident.

Recommendations

The EQRO recommends MHD provide technical assistance to HB in the following areas to improve HB's future audit outcomes and alignment with contract and regulatory requirements:

- HB would benefit from technical assistance from MHD to ensure that their care management software system data elements are properly mapped to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report.
- Misuse of the 'Alternative Therapies for Chronic Pain Management' and 'Authorization Exceptions Request' forms by providers presents an opportunity for targeted education. This can be addressed through individualized outreach, such as requesting additional information from the provider. Additionally, broader communication – such as inclusion in a provider bulletin – may be considered to reinforce appropriate use and clarify expectations. A similar approach could be adopted to address the issue of the 'Appointment of Representation' form missing from appeal request submissions.
- Conduct a review of HB PA workflows to identify the root cause of limited requests for additional information. This analysis will help uncover whether the low frequency of information requests reflects efficiency gains, system limitations or potential compliance risks.
- A timeliness pass rate of 90.8 % was recorded for HB. Among the 34 cases that did not meet the standard, a delay was observed between the denial determination and the communication of that decision to the requesting provider. This highlights an opportunity to review the related workflow, identify the root cause of the delay and implement improvements to ensure the pass rate continues to exceed the 90% requirement.
- HB should collaborate with MHD to establish clear protocols and expectations for managing administrative denials, including documentation standards, workflows and communication guidelines.

Home State Health

HSH had an overall pass score of 97.7%. Table 135 shows the Pass/Not-Pass rates by focus area for HSH.

Table 135. HSH Audit Results by Focus Area.

Pass/Not-Pass Rates	Process Focus Area 1	Criteria Focus Area 2	Criteria Focus Area 3
Pass Volume	365	373	370
Not-Pass Volume	13	5	8
Total Volume	378	378	378
Pass Percentage	96.6%	98.7%	97.9%

Strengths

- EPSDT guidelines, in addition to applicable medical necessity criteria, are clearly being incorporated into HSH's reviews.
- HSH's requests for information include a P2P offer.
- Denial correspondence issued by an HSH vendor includes an appeal form.

- Routine outbound calls to providers to communicate review determinations was consistently observed and is considered a best practice example of HSH's commitment to timely and effective notification.
- HSH's pass percentages for timeliness, selection and application of medical necessity criteria/clinical guidelines, and rationale in denial determination were 96.6%, 98.7% and 97.9%, respectively.

Weaknesses/Opportunities for Improvement

- HSH's decision date and time transmitted to MHD on the 'Prior - Authorizations and Denial Log' report generally aligns with the date and time of the review decision and *not* the correspondence transmission date and time. One noted exception is administrative denials.
- HSH's denial determinations for therapies (PT, OT, ST) are not rendered by HSH's medical directors.
- HSH's requests for information include inconsistent response time instructions (i.e., as soon as possible, date without time). In addition, two types of information requests were identified: general and specific. General requests are typically issued at the point of intake, whereas specific requests occur after an initial clinical review. This distinction highlights an opportunity to evaluate processes to ensure that unnecessary administrative burden is not placed on providers and that timeliness metrics remain accurate and unaffected.
- The dismissal of HSH's appeal requests due to the submitting party's failure to include an 'Authorized Representative Designation' form and/or a written appeal request was observed.
- HSH's generation of updated correspondence following post-decision P2P conversations was not consistently evident.
- HSH's correspondence footer includes an 'approval code' and 'approval date', both of which appear to be related to the letter template naming convention. This verbiage may lead to recipient confusion.
- When duplicate HSH requests for PA are submitted, the denial rationale conveys that the service was already approved. While there is reference made to the approval date, the associated PA number was not included.
- Inconsistency in the handling of HSH adverse determinations for seemingly administrative reasons (i.e. non-covered service/benefit exclusion, late notification, member ineligibility) was noted. Some were reviewed by HSH's medical director, and others were processed without HSH medical director involvement.

Recommendations

The EQRO recommends MHD provide technical assistance to HSH in the following areas to improve HSH's future audit outcomes and alignment with contract and regulatory requirements.

- HSH would benefit from technical assistance from MHD to ensure that their care management software system data elements are properly mapped to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report.
- Medical necessity denial determinations for outpatient therapies are made by licensed professionals, PT, OT and ST, based on their respective disciplines; however, denials should not be issued without support from HSH's medical director. Any exceptions to this standard should

be reviewed with MHD to ensure consistency and compliance. Additional information can be found in MHD Provider Bulletin, Volume 47 Number 17, dated Aug. 20, 2024.

- Requests for information influence timeframes within which MCPs must issue PA determinations. The use of two distinct request types, general and specific, may introduce compliance risks by creating inaccurate turnaround time reporting and leading to regulatory scrutiny. These processes should be evaluated to ensure that all requests for information are clinically justified and aligned with applicable standards. In addition, requests for information should include clear, actionable instructions for the recipient. This guidance must specify the expected response timeframe, including the exact date and time by which a reply is required.
- Requesting providers failing to include an 'Authorized Representative Designation' form and/or a written appeal request presents an opportunity for targeted education. This can be addressed through individualized outreach, such as requesting additional information directly from the requesting party. Broader communication – such as inclusion in a provider bulletin or dissemination of member educational materials – may be considered to clarify and reinforce appeal submission expectations.
- HSH should collaborate with MHD to establish clear protocols and expectations for managing administrative denials, including documentation standards, workflows and communication guidelines.
- Placing outbound calls to providers to relay review determinations was observed as a standard HSH operating procedure; however, it is unclear what the practice is when a connection is not made. Additional discovery and potentially staff training in this area is recommended.

Show Me Healthy Kids

SMHK had an overall pass score of 96.3%. Table 136 below shows the Pass/Not-Pass rates by focus area for SMHK.

Table 136. SMHK Audit Results by Focus Area.

Pass/Not-Pass Rates	Process Focus Area 1	Criteria Focus Area 2	Criteria Focus Area 3
Pass Volume	321	315	323
Not-Pass Volume	11	17	9
Total Volume	332	332	332
Pass Percentage	96.7%	94.9%	97.3%

Strengths

- EPSDT guidelines, in addition to applicable medical necessity criteria, are clearly being incorporated into SMHK's reviews.
- P2P offers are incorporated into SMHK's requests for information.
- Denial correspondence issued by an HSH vendor includes an appeal form.
- In behavioral health cases, SMHK's medical director proactively contacted the requesting provider prior to making PA determinations. Engaging the requesting provider before rendering a decision promotes transparency, reduces the risk of miscommunication and supports clinically sound decisions.

- Routine outbound calls to providers to communicate review determinations was consistently observed and is considered a best practice example of SMHK's commitment to timely and effective notification.
- SMHK's pass percentages for timeliness, selection and application of medical necessity criteria/clinical guidelines, and rationale in denial determination were 96.7%, 94.9% and 97.3%, respectively.

Weaknesses/Opportunities for Improvement

- SMHK's decision date and time transmitted to MHD on the 'Prior - Authorizations and Denial Log' report generally aligns with the date and time of the review decision and *not* the correspondence transmission date and time. One noted exception is administrative denials.
- Denial determinations for therapies (PT, OT, ST) are not rendered by SMHK's medical directors.
- SMHK requests for information include inconsistent response time instructions (i.e., as soon as possible, date without time). In addition, two types of information requests were identified: general and specific. General requests are typically issued at the point of intake, whereas specific requests occur after an initial clinical review. This distinction highlights an opportunity to evaluate processes to ensure that unnecessary administrative burden is not placed on providers and that timeliness metrics remain accurate and unaffected.
- Some SMHK appeal requests were dismissed due to the 'Authorized Representative Designation' form and/or written request not being received within the required timeframe.
- When duplicate SMHK requests for PA are submitted, the denial rationale conveys that the service was already approved. While there is a reference made to the approval date, a PA number was not included.
- Inconsistency in the handling of SMHK's adverse determinations for seemingly administrative reasons (i.e. non-covered service/benefit exclusion, late notification, member ineligibility) was noted. Some were reviewed by SMHK's medical director, and others were processed without SMHK medical director involvement.

Recommendations

The EQRO recommends MHD provide technical assistance to SMHK in the following areas to improve SMHK's future audit outcomes and alignment with contract and regulatory requirements.

- SMHK would benefit from technical assistance from MHD to ensure that their care management software system data elements are properly mapped to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report.
- SMHK medical necessity denial determinations for outpatient therapies are made by licensed professionals, PT, OT and ST, based on their respective disciplines; however, denials should not be issued without support from the MCP medical director. Any exceptions to this standard should be reviewed with MHD to ensure consistency and compliance. Additional information can be found in MHD Provider Bulletin, Volume 47 Number 17, dated Aug. 20, 2024.
- Requests for information influence timeframes within which MCPs must issue PA determinations. The use of two distinct request types, general and specific, may introduce compliance risks by creating inaccurate turnaround time reporting and leading to regulatory scrutiny. These processes should be evaluated to ensure that all requests for information are clinically justified and aligned with applicable standards. In addition, requests for information

should include clear, actionable instructions for the recipient. This guidance must specify the expected response timeframe, including the exact date and time by which a reply is required.

- Failure to include an 'Authorized Representative Designation' form and/or a written appeal request presents an opportunity for targeted education. This can be addressed through individualized outreach, such as requesting additional information directly from the requesting party. Broader communication – such as inclusion in a provider bulletin or dissemination of member educational materials – may be considered to clarify and reinforce appeal submission expectations.
- SMHK should collaborate with MHD to establish clear protocols and expectations for managing administrative denials, including documentation standards, workflows and communication guidelines.
- Placing outbound calls to providers to relay review determinations was observed as a standard SMHK operating procedure; however, it is unclear what the practice is when a connection is not made. Additional discovery and potentially staff training in this area is recommended.

UnitedHealthcare

UHC had an overall pass score of 93.1%. Table 137 below shows the Pass/Not-Pass rates by focus area for UHC.

Table 137. UHC Audit Results by Focus Area.

Pass/Not-Pass Rates	Process Focus Area 1	Criteria Focus Area 2	Criteria Focus Area 3
Pass Volume	305	374	368
Not-Pass Volume	70	1	7
Total Volume	375	375	375
Pass Percentage	81.3%	99.7%	98.1%

Strengths

- EPSDT guidelines, in addition to applicable medical necessity criteria, are clearly being incorporated into UHC's reviews.
- Evidence of auto-approval functionality was observed. Automation leads to efficiencies such as faster response times and decreased administrative burden to requesting providers.
- UHC's care management system has the ability for users to be assigned based upon competency and/or work schedules. This was evident in notes stating, 'Case rejected reason: Competency change' and 'Case rejected reason: End of shift.' This functionality optimizes UHC's ability to operate with a staffing model that ensures reviews are assigned according to work schedule and conducted by professionals with direct experience in specialty areas.
- Status updates (pending clinical review, pending medical director review) are issued throughout the UHC review process.
- Correspondence generation appears to be automated and correlates with UHC's medical director decision.
- Correspondence is made available to some UHC members and providers via their respective portals.

- When requests are made by out-of-network providers, in-network provider options are included in the UHC denial correspondence.
- Correspondence was frequently shared with PCPs in addition to the requesting and servicing providers. This represents a best practice example of UHC's commitment to care coordination.
- There was a noted pattern of multiple attempts to obtain all necessary information.
- Integration with service provider is evident in request source designation of 'Children's Mercy Auth Log.'
- UHC's pass percentages for selection and application of medical necessity criteria/clinical guidelines and rationale in denial determination were 99.7% and 98.1%, respectively.

Weaknesses/Opportunities for Improvement:

- UHC's DCN and PA numbers do not match what is being transmitted to MHD on the 'Prior - Authorizations and Denial Log.'
- Each service code in a UHC request is assigned a unique reference number, not necessarily in chronological order. It appears that the first service code entered becomes the primary reference number for the case.
- UHC correspondence templates appear to contain writing prompts (i.e., '

') which drive the user to insert required text. Improper use of these cues results in the prompts remaining in the body of denial letters.
- UHC grievance instructions are difficult to read due to the poor image quality. Some versions are more focused on discrimination. Both appear to be included with denial letters as supplemental documents.
- When duplicate requests for PA are submitted, the UHC denial rationale conveys that the service was already approved. While there is a reference made to the approval date, the PA number was not included.
- UHC requests submitted by telephone appeared to be associated with automated requests for information.
- UHC requests for information do not consistently include response date and time parameters.
- UHC requests for information, particularly when there are multiple services requested, are divided into separate faxes. This appears to be related to document size restrictions.
- Inconsistency in the handling of UHC adverse determinations for seemingly administrative reasons (i.e. non-covered service/benefit exclusion, late notification, member ineligibility) was noted. Some were reviewed by UHC's medical director, and others were processed without UHC medical director involvement.
- A standardized process for managing UHC post-decision submission of clinical documentation is not evident.
- At least one of UHC's vendors is not delegated to send written correspondence following reconsiderations. It is unclear how that process is completed.

Recommendations

The EQRO recommends MHD provide technical assistance to UHC in the following areas to improve UHC's future audit outcomes and alignment with contract and regulatory requirements:

- UHC would benefit from technical assistance from MHD to ensure that their care management software system data elements are properly mapped to the corresponding fields in the 'Prior - Authorizations and Denial Log' quarterly report.
- A timeliness pass rate of 81.3% was recorded for UHC. There were 70 cases that did not meet the standard. Contributing factors lie in two separate segments of the utilization review process: 1. Delay from the initial clinical reviewer's referral to a medical director and the subsequent rendering of the medical director's determination, and 2. Elapsed time between recording the medical director's decision and communicating the determination to the requesting provider. These findings highlight an opportunity to review UHC's related workflows, identify the root cause(s) of delays and implement improvements to ensure the pass rate consistently exceeds the 90% requirement moving forward.
- Requests for information should include clear, actionable instructions for the recipient. UHC should ensure the following actions are taken to improve requests for information:
 - Specify the expected response timeframe, including the exact date and time by which a reply is required.
 - Identify and address the underlying reason for transmitting multiple faxes.
 - Evaluate the appropriateness of automatically issuing a request for information (this was primarily observed when service requests are initiated via telephone).
- UHC should collaborate with MHD to establish clear protocols and expectations for managing administrative denials, including documentation standards, workflows and communication guidelines.

Progress on Previous Year's EQRO Recommendations

Effective Sept. 18, 2024, MHD contracted with Comagine Health to develop the PA audit program. The PA audit program began on March 17, 2025, marking 2025 as its first year of reporting. Updates to the current year's EQRO recommendations will be included in the *2026 EQR Annual Technical Report*.

Secret Shopper Survey

Objective

To assess MCPs' compliance with federal requirements under §§438.206 and 438.68, a Secret Shopper survey is used to evaluate the accessibility and adequacy of provider networks. The survey allows the EQRO to assess appointment wait times and the accuracy of online provider directory information, with a focus on identifying barriers to accessing care.

Overview

In Medicaid EQR guidelines, Secret Shopper surveys are used to verify whether MCP provider network directories are accessible and accurate and if appointment wait times are within contracted limits. This process helps ensure that Medicaid beneficiaries have accurate and timely access to care without encountering barriers related to incorrect contact information or provider availability.

These surveys are part of the broader quality improvement efforts mandated by CMS to monitor and improve the quality of care delivered to beneficiaries. They contribute to assessing compliance with network adequacy standards and can help identify areas where improvements are needed to enhance access to care. Therefore, conducting such surveys in compliance with EQR guidelines is crucial for maintaining the integrity and effectiveness of Medicaid programs.

Methodology

Technical Methods of Data Collection

Secret Shopper Standards

The Secret Shopper standards were established in sections 2.13.17 and 2.6.3 of the MHD MCP contract. The Secret Shopper Survey was designed to simulate the experience of a case worker using an online provider directory to learn more about the service location and appointment availability for their clients. This design is intended to resemble the member experience while allowing the collection of multiple data elements that would be cumbersome to collect if simulating a call by a single member.

The Secret Shopper Primary Care Provider (PCP) survey included service locations in Missouri, or contiguous states, with providers who were indicated as both being PCPs and accepting new patients in the online provider directory.

The Secret Shopper Psychiatrist (PSYCH) survey included service locations in Missouri, or contiguous states, with providers whose primary specialty listed was identified by MHD as a patient facing psychiatric specialty and who were indicated to be accepting new patients in the online provider directory.

Table 138 and Table 139 show the survey response rate for PCPs and psychiatrists.

Table 138. Survey Response Rate – PCPs.

PCP Survey	HB	HSH/SMHK	UHC	MO
Office Staff Agrees to Survey	347	318	311	976
Office Staff Disagrees to Survey	10	13	11	34
Total Number of Surveys	357	331	322	1,010
Response Rate	97.2%	96.1%	96.6%	96.6%

Table 139. Survey Response Rate – Psychiatrists.

PSYCH Survey	HB	HSH/SMHK	UHC	MO
Office Staff Agrees to Survey	175	157	176	508
Office Staff Disagrees to Survey	28	44	27	99
Total Number of Surveys	203	201	203	607
Response Rate	86.2%	78.1%	86.7%	83.7%

Description of Data Obtained

Survey responses were aggregated by analyzing response data across multiple calls, focusing on the following metrics:

Accepting New Patients

The survey evaluated provider availability by assessing the percentage of PCPs and psychiatrists listed as accepting new Medicaid patients. MCPs are expected to ensure that at least 72% of these providers are accepting new patients. This was measured using July 2025 online provider directory data, comparing the number of providers listed as accepting new patients to the total number in the network. The Secret Shopper Survey was then used to verify whether providers or their service locations were accurately listed as accepting new patients.

Appointment Standards

The survey evaluated MCPs based on their adherence to appointment standards established in sections 2.13.17 and 2.6.3 of the MHD MCP contract. Routine care without symptoms, such as preventive or wellness visits, must be scheduled within 30 calendar days. Appointments for routine care involving symptoms are required within five business days or one week, whichever is sooner. Aftercare following a hospital discharge must occur within seven calendar days. Urgent care for non-emergency physical or behavioral health concerns must be available within 24 hours.

Appointment standards were evaluated based on a service location being able to provide an appointment with the specified provider type, not with a specific provider.

Provider Directory Accuracy

The survey evaluated the accuracy of managed care plans' online provider directories. This includes verifying that an entry in the online provider directory is accurate for the following elements: telephone number, address and is accepting new patients from the Medicaid plan. All providers included in the Secret Shopper survey were indicated to be Accepting New Patients in the online provider directories. The online provider directory data was provided by each MCP prior to each survey cycle.

Data Aggregation and Analysis

The survey was administered between February and October 2025 and included three survey cycles. Plans provided updated copies of online provider directory files prior to each cycle to ensure data used by surveyors closely reflected data that was available online. Provider service locations were deduplicated to ensure service locations were only included once during the survey period, regardless of the number of providers who service that location.

The findings outlined below evaluate Access and Timeliness.

Overall Survey Results

The results from the CY2025 Secret Shopper Survey are included in the tables below for each MCP and the overall aggregate program level (MO). A more detailed analysis can be found in the CY2025 Secret Shopper Executive Summary Report.

Table 140 and Table 141 show the number of primary care providers who are accepting new patients as evaluated based on the number of individual PCP providers listed in the online provider directory in July 2025, and results from the 2025 Secret Shopper Survey. Providers in the provider directory were considered to be accepting new patients if they had open panels in at least one service location. The Secret Shopper Survey only included those providers listed as “Accepting New Patients” and evaluated if any primary care provider or psychiatrist at a service location was accepting new patients from the MCP. The contract requirement is $\geq 72\%$.

Table 140. Provider Directory Results: Accepting New Patients – PCPs.

PCPs Accepting New Patients—Provider Directory	HB	HSH/SMHK	UHC	MO
Primary Care Providers Accepting New Patients	3912	2831	3668	10411
Primary Care Providers Not Accepting New Patients	230	231	331	792
Total Volume	4142	3062	3999	11203
Percentage Accepting New Patients	94.4%	92.5%	91.7%	92.9%

Table 141. Survey Results: Accepting New Patients – PCPs.

PCPs Accepting New Patients—Secret Shopper Survey	HB	HSH/SMHK	UHC	MO
Primary Care Providers Accepting New Patients	289	210	212	711
Primary Care Providers Not Accepting New Patients	37	56	44	137
Total Volume	326	266	256	848
Percentage Accepting New Patients	88.7%	78.9%	82.8%	83.8%

Table 142 and Table 143 shows the number of psychiatrists who are accepting new patients as evaluated based on the number of individual psychiatric providers listed in the online provider directory in July 2025 and results from the Secret Shopper Survey. The Secret Shopper Survey only included those providers listed as Accepting New Patients. The contract requirement is $\geq 72\%$.

Table 142. Provider Directory Results: Accepting New Patients – Psychiatrists.

Psychiatrists Accepting New Patients—Provider Directory	HB	HSH/SMHK	UHC	MO
Psychiatrists Accepting New Patients	343	300	370	1013
Psychiatrists Not Accepting New Patients	15	7	0	22
Total Volume	358	307	370	1035
Percentage Accepting New Patients	95.8%	97.7%	100.0%	97.9%

Table 143. Survey Results: Accepting New Patients – Psychiatrists.

Psychiatrists Accepting New Patients—Secret Shopper Survey	HB	HSH/SMHK	UHC	MO
Psychiatrists Accepting New Patients	124	117	109	350
Psychiatrists Not Accepting New Patients	15	16	27	58
Total Volume	139	133	136	408
Percentage Accepting New Patients	89.2%	88.0%	80.1%	85.8%

Table 144 shows the percentage of service locations with appointment availability with any primary care provider at that location. Locations that were unable to provide scheduling details without a valid member ID or additional member specific details were excluded. The contract requirement is ≥90%.

Table 144. Survey Results: Appointment Standards – PCPs.

PCP Appointment Standards	HB	HSH/SMHK	UHC	MO
Routine Care Appointments – Within 30 days	85.4%	76.1%	72.6%	78.9%
Routine Care Appointments (with symptoms) – Within 7 days	76.2%	62.1%	68.6%	69.9%
Urgent Care Appointments – Within 24 hours	61.5%	52.3%	56.2%	57.3%

Table 145 shows the percentage of service locations with appointment availability with any psychiatrist at that location. Locations that were unable to provide scheduling details without a valid member ID or member specific details were excluded. The contract requirement is ≥90%.

Table 145. Survey Results: Appointment Standards – Psychiatrists.

Psychiatrist Appointment Standards	HB	HSH/SMHK	UHC	MO
Routine Care Appointments – Within 30 days	72.0%	67.2%	72.3%	70.8%
Routine Care Appointments (with symptoms) – Within 7 days	68.4%	64.0%	68.8%	67.4%
Aftercare Appointment following hospital discharge - Within 7 days	65.4%	60.8%	58.8%	61.9%
Urgent Care Appointments – Within 24 hours	66.2%	58.3%	61.2%	62.4%

Table 146 shows the percentage of online provider directory listings that were accurate as evaluated by phone number, address and if the location was accepting new patients. If a provider directory listing had an inaccuracy in any of the elements evaluated, it was considered inaccurate. Phone numbers that did not connect to primary care or psychiatrist offices were included as inaccurate directory listings. MHD has not established a numeric directory accuracy threshold for the CY2025 measurement year.

Table 146. Survey Results: Provider Directory Accuracy.

Provider Directory Accuracy	HB	HSH/SMHK	UHC	MO
Primary Care Providers	56.9%	45.4%	38.0%	46.8%
Psychiatrists	37.2%	48.0%	31.8 %	38.4%

Summary of Survey Program Level Findings and Recommendations

Primary Care Providers

When evaluating MO HealthNet MCPs providers who were accepting new patients, all MCPs surpassed the 72% target for primary care providers accepting new members and none of the MCPs met the Appointment Standards for routine care, symptomatic care or urgent care. MCPs should prioritize expanding provider networks, expanding appointment availability to after hours and weekends, and addressing barriers that limit access to primary care.

Accurate directories are foundational to member's accessing care and their overall satisfaction. While there were no explicit standards regarding provider directory accuracy, significant issues were identified. To improve directory accuracy, MHD should work with the MCPs to implement routine verification processes, including direct outreach to provider offices, root cause analysis of common errors and collaboration with providers to ensure timely updates. MCPs might explore the use of technology and/or third-party validation services.

Psychiatrists

In 2025, when evaluating MO HealthNet MCP providers who were accepting new patients, all MCPs surpassed the 72% target for psychiatrists accepting new members. However, none of the MCPs met the Appointment Standards for routine, symptomatic, discharge or urgent care. Psychiatric care is highly specialized and often requires detailed member information that this survey design could not capture, resulting in many locations being unable to schedule appointments. This limitation not only hinders evaluation but may also discourage new patients from seeking care.

While there were no explicit standards in 2025 regarding provider directory accuracy, significant issues were identified. To improve directory accuracy and member experience, MHD should work with MCPs to make psychiatric care specialties more accessible and clearly organized within provider directories. Psychiatric services often span multiple provider types with different scopes of practice. These distinctions are frequently unclear or inconsistently labeled in directories, making it difficult for members to identify appropriate providers for their needs.

MHD should work with the MCPs to standardize specialty classifications, improve search functionality and ensure that directory entries accurately reflect provider roles and services offered.

MHD should work with MCPs to implement routine verification processes, including direct outreach to provider offices, root cause analysis of common errors and collaboration with providers to ensure timely updates. MCPs might explore the use of technology and/or third-party validation services.

Survey EQRO Plan Level Recommendations

As 2025 is the first year of reporting for the Secret Shopper Survey, plan level recommendations and required actions will not be issued this year. Plans should proactively address the deficiencies highlighted by the survey.

Progress on Previous Year (2024) Survey EQRO Program Level Recommendations

Effective Jan. 1, 2024, MHD contracted with Comagine Health to develop the Secret Shopper Survey, with implementation beginning on Jan. 1, 2025, marking 2025 as its first year of reporting. Updates to the current year's EQRO recommendations will be included in the CY2026 EQR Annual Technical Report.

Appendix A: PIP Validation Methodology

The intent of the PIP validation process is to ensure that a PIP contains sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that the PIP has a comprehensive and logical thread that ties each aspect (e.g., aim statement, sampling methodology and data collection) together.

As required under *CMS Protocol 1. Validation of Performance Improvement Projects (PIPs)*, Comagine Health determined whether PIP validation criteria were Met, Partially Met or Not Met. In addition, Comagine Health utilizes validation ratings in reporting the results of the MCPs' PIPs.

Technical Methods of Data Collection

The PIP validation, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted June through October 2025, for MCP PIPs conducted between Jan. 1, 2024 through Dec. 1, 2024. The review followed the guidelines from *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*, a set of worksheets used to guide and record answers for the validation of PIPs and reporting of summary PIP information, developed by CMS to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

CMS Protocol 1 specifies procedures in assessing the validity and reliability of a PIP and how to conduct the following three activities:

Activity 1 (Standards): Assess the PIP Methodology

1. Review the selected PIP topic to assess the appropriateness of the selected topic
2. Review the PIP aim statement to assess the appropriateness and adequacy of the aim statement
3. Review the identified PIP population to assess whether the population was appropriately identified
4. Review the appropriateness of the sampling method
5. Review the appropriateness of the selected PIP variables and performance measures
6. Review the appropriateness of the study variables and performance measures used to track improvement in the data collection procedures
7. Review the data analysis and interpretation of PIP results to assess the quality and completeness of the analysis
8. Assess whether the improvement strategies selected were appropriate for achieving improvement
9. Assess the likelihood that significant and sustained improvement occurred was the result of the PIP

Activity 2: Perform Overall Validation & Reporting of PIP Results

Following the completion of Activity 1, the EQRO will provide two validation ratings of the PIP results:

- **Validation Rating 1:** The EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases (Standards 1-8)
- **PIP Validation Rating 2:** The EQRO's overall confidence that the PIP produced evidence of significant improvement (Standard 9)

The “validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results and produced evidence of significant improvement.

Comagine Health utilizes one of the following validation ratings in reporting the results of the MCPs’ PIPs:

- High confidence in reported results
- Moderate confidence in reported results
- Low confidence in reported results
- No confidence in reported results

Activity 3: Verify PIP Findings (Optional)

A state may request that the EQRO verify the data produced by the MCP to determine if the baseline and repeated measurements are accurate. The MCPs’ data was based on the following:

- HEDIS measures, which have been validated via the MY2024 HEDIS compliance audit process conducted according to the standards and methods described in the NCQA HEDIS® Compliance Audit™ Standards, Policies and Procedures.
- CAHPS survey results. The CAHPS program is a public-private initiative that develops standardized surveys to measure patients’ experiences with health care. The surveys are designed to be reliable and to allow for comparisons across health care settings. These surveys cover topics that are important to consumers, such as the communication skills of providers and how easy it is to access health care services.

Therefore, Comagine Health did not verify the data produced by the MCPs.

Description of Data Obtained

Comagine Health validates each PIP using data gathered and submitted by the MCP using the Research Electronic Data Capture (REDCap) system based on the *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*. REDCap is a secure web-based application designed for data collection and management in research and clinical studies.

Data Aggregation and Analysis

As the MCPs submit their PIP data directly within the protocol worksheets, all elements necessary for the validation of the PIP are submitted and readily available for Comagine Health to validate.

The Comagine Health scoring method for evaluating PIPs is outlined below.

Scoring

Validation Ratings and Overall Score

Each standard has a specified number of scoring elements, which correlate to the PIP validation worksheets. Element score results are presented as either “Yes,” “No” or “Not Applicable (NA)” based on the reviewer’s evaluation of the MCP’s responses and documents submitted. Elements scored NA are not reviewed and are not included in the final scoring. Standard scores are presented as the number of “Yes” elements out of the total number of scoring elements possible for each validation rating.

The PIP overall score is based on the nine individual validation standard scores. The overall score is presented as the total number of “Yes” results out of the number of scoring elements possible for each of the nine individual validation standard scores.

Table A-1 below provides a percentage score, which correlates with the overall score and validation rating that aligns with CMS Protocol 1.

Table A-1. PIP Validation Rating and Overall Score Legend.

Percentage of Validation Steps Met	Validation Rating (Confidence Level)	Overall Score
90.0% – 100%	High confidence in reported results	Met
80.0% – 89.9%	Moderate confidence in reported results	Partially Met
70.0% – 79.9%	Low confidence in reported results	Not Met
≤ 69.9%	No confidence in reported results	Not Met

Strengths are given for standards that scored at or above 90%. For standard element findings of “No,” the EQR team documented the requirements related to the findings and provided recommendations, followed by the issuance of a required action (RA), formerly known as a corrective action plan.

Appendix B: PMV Methodology

Technical Methods of Data Collection

Performance measures validation for MY2022 through MY2024 was conducted in August 2025. The review followed the guidelines from *CMS EQR Protocol 2: Validation of Performance Measures*.

According to §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and §438.358. The performance measures identified by MHD for validation are NCQA HEDIS measures and are validated by an NCQA-certified HEDIS auditor.

Comagine Health did not validate the measures, but did conduct an analysis of the reported results in the FAR. The review consisted of the following three activities:

- **Conduct pre-site visit activities** – Comagine Health worked with MHD to identify performance measures for validation and determine process for review. MHD opted to utilize validation results from the NCQA HEDIS measures to avoid duplication.
- **Conduct site visit activities** – No site visits were conducted since validation of the identified performance measures was completed by NCQA-certified HEDIS compliance auditor. Comagine Health obtained copies of these reports and supporting data from the MCPs.
- **Conduct post-site visits activities** – The MCP's FAR reports and data were analyzed. Findings include the identification of measures as either a strength, being compliant or an opportunity for improvement. Results are reported to MHD and the MCPs.

Description of Data Obtained

The following data was obtained for the validation:

- FAR reports for the HEDIS Compliance Audit™
- Numerator and denominator data for each performance measure
- NCQA Quality Compass®³⁰

The Data comprises audited performance rates and associated benchmarks for HEDIS measures and measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician that uses or reports performance measures or any data or rates calculated using HEDIS measures and specifications and NCQA has no liability to anyone who relies on such measures or specifications.

NCQA holds a copyright in Quality Compass and the Data and may rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, non-commercial purpose may do so without obtaining any approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at its discretion.

³⁰ The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® 2023 and is used with the permission of NCQA. Any analysis, interpretation or conclusion based on the Data is solely that of the authors and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

HEDIS Compliance Audit Process

The MY2022 through MY2024 HEDIS compliance audit processes were conducted by an NCQA certified HEDIS auditor. The performance measures identified by MHD for validation are NCQA HEDIS measures and were validated according to the standards and methods described in the NCQA *HEDIS® Compliance Audit™ Standards, Policies and Procedures*. The audit had the following components:

- An overall assessment of the capability of information systems to capture and process the information required for reporting (also referred to as the ISCA)
- An evaluation of the processes that were used to prepare individual measures
- An assessment of the accuracy of rates reported

The review of information systems was performed to collect information that documents the MCP's efforts to ensure the accuracy and completeness of reported HEDIS rates. The findings from the information capabilities assessment formed the basis of a closer examination of the procedures used to develop the various HEDIS measures.

Data Aggregation and Analysis

The MCP's FAR statements, along with numerator and denominator data for each performance measure were analyzed. The NCQA Quality Compass was used to identify national benchmarks.

Comagine Health employed SAS software to perform the Wilson Score Interval Test.³¹ This statistical test calculates 95% confidence intervals that are used to determine if there was a statistically significant change. In layman's terms, this indicates the reader can be 95% confident there is a real difference between two numbers and that the differences are not just due to random chance.

The confidence interval is expressed as a range from the lower confidence interval value to the upper confidence interval value. A statistically significant improvement is identified if the current performance rate is above the upper confidence interval for the previous year. A statistically significant decline is identified if the current performance rate is below the lower confidence interval for the previous year.

The results of the test identified which changes were statistically significant or whether changes were due to normal variation.

Calculation of the Medicaid State Rate (MSR)

The MSR for a given measure is calculated using the reported data from the four MCPs (HB, HSH, SMHK, UHC) for that measure. Each MCP reported numerator and denominator data for each measure. That data was aggregated to obtain the MSR.

Interpreting Percentages vs. Percentiles

The majority of the measure results in this report are expressed as percentages. The actual percentage shows a plan's specific performance on a measure. For example, if Plan A reports a Lead Screening in Children rate of 49%, that means that 49% of the eligible children enrolled in Plan A received the screening. Ideally, 100% of eligible children should receive lead screening screenings. The actual rate indicates there is still a gap in care that can be improved.

³¹ Note that past versions of this report used a Pearson's Chi Square test to identify year-over-year statistically significant changes. Upon review, Comagine Health determined the Wilson Score Interval is the more appropriate test for trended results.

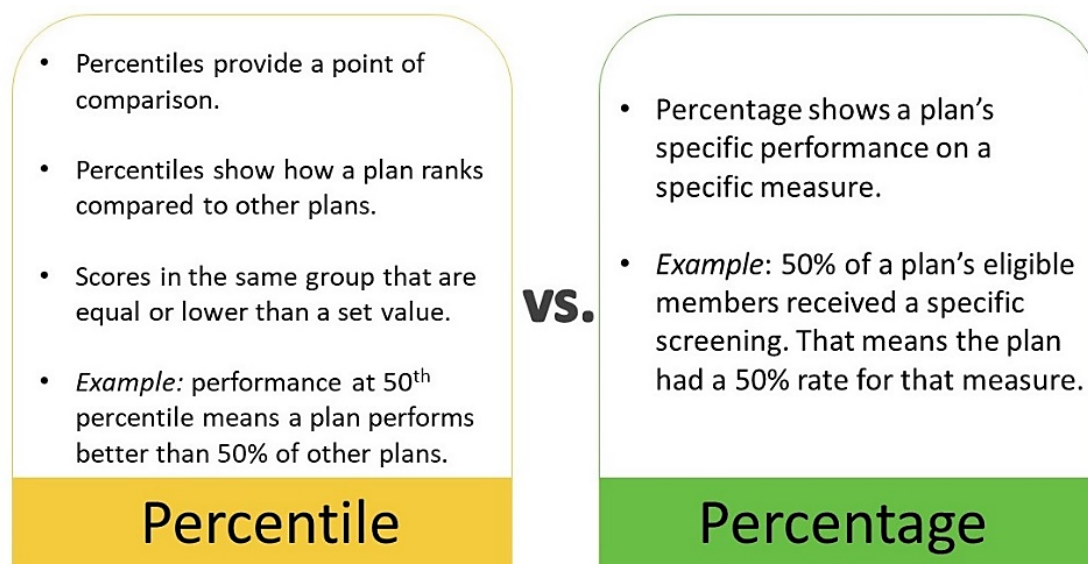
The national benchmarks included in this report are often displayed as percentiles. The percentile shows how Plan A ranks among all other plans reporting the Lead Screening in Children rates. For example:

- If a plan's Lead Screening in Children rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above.
- If Plan A is above the 75th percentile, that means that at most 25% of the plans in the nation reported rates above Plan A and at least 75% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important in identifying high priority areas for quality improvement. For example, if Plan A performs below the 50th percentile, it can be concluded that there is considerable room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 75th percentile, it can be concluded that performance on that particular measure already exceeds the performance of most other plans and that improving the actual rate for that measure may not be the highest priority for this plan.

Figure B-1 shows the differences between percentiles and percentages in the context of this report.

Figure B-1. Percentile Vs. Percentage.



Scoring

Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles:

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 50th and 75th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Appendix C: Compliance Methodology and Scoring

Methodology

Comagine Health's review assesses activities for the previous calendar year and evaluates the standards set forth in 42 CFR Part 438, as well as those established in the MCPs' contract with MHD.

Technical Methods of Data Collection

The compliance review, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted between March and July 2025, for MCP compliance activities conducted between Jan. 1, 2024 through Dec. 1, 2024. The review followed the guidelines from *CMS EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*. The review consisted of the following five activities:

- **Establish compliance thresholds** – Comagine Health worked with MHD to develop the processes, scoring methods, tools and compliance thresholds for the selected standards to be reviewed.
- **Perform the preliminary review (desk review)** – Desk review includes assessment of MCP operations and practices, utilizing documentation submitted by the MCP and verification activities to confirm practices. The verification activity included a sample of providers from the MCP's provider network to confirm credentialing processes for qualified providers were implemented.
- **Conduct the MCP virtual site visit** – Interviews are held to collect additional information necessary to assess the MCP's compliance with federal and state standards and to clarify identified gaps and questions that arise from the review of the completed desk review. Participants in the interview sessions included MCP administrators, supervisors and other staff responsible for supporting care managers, staff responsible for improvement efforts and CM staff.
- **Compile and analyze findings** – The MCP's written documentation and responses to interview questions are used to score the performance on each element reviewed. Findings will include strengths, weakness/opportunities for improvement, recommendations and progress on prior EQRO recommendations from the previous year. Progress efforts will be ranked high, medium, low or not applicable.
- **Report results to the state** – Each report covers the specific review elements and corresponding sections of 42 CFR §438, MHD's contract with the MCP and other state regulations where applicable in compliance with §438.364.

Description of Data Obtained

Documents obtained and reviewed include a wide range of process-related materials depending on the area of focus, such as program descriptions, program evaluations, policies and procedures, meeting minutes, desk manuals, staff training plans, data submissions, results and analysis of internal monitoring, narrative reflections on progress, reports, MCP internal tracking tools or other MCP records.

The verification activity documentation for EQR purposes includes the categories listed below, as appropriate:

- Provider credentialing

- Denials – adverse benefit determinations/actions
- Appeals, including the denial portion of the file
- Grievances

Data Aggregation and Analysis

MCPs submitted documentation are stored and reviewed in databases, aligning with federal and applicable state regulations, as well as meeting contractual requirements with MHD. The databases are standardized data collection systems which store the following information:

- Requirements (standards under review)
- Documentation of findings from organizational document review
- Customized interview questions
- Rating of compliance by standard
- Rationale for compliance/non-compliance
- Recommendations for the organization
- Documentation from interviews with the organization

Scoring

Each standard has a specified number of scoring elements, which correlate with federal standards and MHD Contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 3 (Table C-1).

Table C-1. Compliance Scoring Legend.

Score	Compliance Rating
90.0% - 100%	Fully Met
80.0% - 89.9%	Substantially Met
70.0% - 79.9%	Partially Met
60.0% - 69.9%	Minimally Met
≤ 59.9%	Not Met

The following definitions are used to determine compliance for each scoring element:

Compliant: All policies, procedures and practices were aligned to meet the requirements, practices were implemented, and monitoring was sufficient to ensure effectiveness.

Not compliant: The MCP met the requirements in practice but lacked written policies or procedures, or the organization had not finalized or implemented draft policies, or monitoring had not been sufficient to ensure effectiveness of policies, procedures and practices.

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

Table C-2, Table C-3 and Table C-4 summarize the compliance results of the four MCPs and provides an aggregate overview (MO)³² of those results within the last three years.

Table C-2. Individual MCP Compliance and Program Level Results, CY2023.

Std.	42 CFR Citation	HB	HSB	SMH	UHC	MO
Q1	General rules – §438.330(a)	100%	100%	100%	85.7%	95.2%
Q2	Basic elements of quality assessment and performance improvement programs – §438.330(b)	100%	100%	100%	100%	100%
Q3	Performance measurement – §438.330(c)*	NA	NA	NA	NA	NA
Q4	Performance improvement projects – §438.330(d)*	NA	NA	NA	NA	NA
Q5	Program and review by the state – §§438.330(e)(2)	100%	100%	100%	100%	100%

* Q3 is assessed annually as part of the MCP's PMV, while Q4 is evaluated annually through the MCP's PIP Validation. Both are conducted separately from the Compliance with Standards Review.

Table C-3. Individual MCP Compliance and Program Level Results, CY2024.

Std.	42 CFR Citation	HB	HSB	SMHK	UHC	MO
M1	Availability of services – §438.206	100%	100%	100%	100%	100%
M2	Furnishing of services and timely access – §438.206(c)(1)	100%	100%	100%	100%	100%
M3	Access and cultural considerations in services – §438.206(c)(2)	100%	100%	100%	100%	100%
M4	Assurances of adequate capacity and services – §438.207*	NA	NA	NA	NA	NA
M5	Coordination and continuity of care, and confidentiality – §§438.208, 438.224	90.9%	100%	100%	90.9%	96%
M6	Additional coordination and continuity of care requirements – §438.208(c)	50%	100%	100%	50%	81.8%
M7	Disenrollment: requirements and limitations - §438.56	100%	100%	100%	100%	100%
M8	Coverage and authorization of services – §§438.210, 440.230, 438.441 Emergency and post-stabilization services – §438.114	100%	100%	100%	100%	100%
M9	Information requirements for all enrollees – §§438.100(b)(2)(i), 438.10	72.7%	90.9%	90.9%	72.7%	81.8%
M10	Enrollee right to receive information on available provider options – §§438.100(b)(2)(iii), 438.102	66.7%	66.7%	66.7%	100%	75%
M11	Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint – §§438.100(b)(2)(iv) and (v), 438.3(j)	100%	60%	50%	100%	76.2%
M12	Compliance with other federal and state laws – §438.100(d)	0%	100%	100%	100%	75%

³² Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO
M13	Provider selection – §438.214	100%	77.8%	77.8%	88.9%	86.1%
M14	Subcontractual relationships and delegation – §438.230	100%	100%	100%	100%	100%
M15	Practice guidelines – §438.236	80%	80%	80%	100%	85%
M16	Health information systems – §438.242*	NA	NA	NA	NA	NA

* M4 is evaluated as part of the MCP's Network Adequacy Validation conducted annually. M16 is evaluated as part of the MCP's ISCA conducted once every three years. The Network Adequacy Validation and ISCA occur separate from the compliance with standards review.

Table C-4. Individual MCP Compliance and Program Level Results, CY2025.

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO
G1	§438.228 – Grievance and appeal systems	33.3%	100%	100%	100%	83.3%
G2	§438.402 – General requirements	85.7%	100%	100%	100%	96.4%
G3	§438.404 – Timely and adequate notice of adverse benefit determination	87.5%	100%	100%	100%	96.9%
G4	§438.406 – Handling of grievances and appeals	90.0%	90.0%	90.0%	100%	92.5%
G5	§438.408 – Resolution and notification, Grievances and appeals	85.7%	85.7%	85.7%	85.7%	85.7%
G6	§438.410 – Expedited resolution of appeals	50.0%	100%	100%	100%	87.5%
G7	§438.414 – Information about the grievance and appeal system to providers and subcontractor	100%	100%	100%	100%	100%
G8	§438.416 – Recordkeeping requirements	100%	100%	100%	100%	100%
G9	§438.420 – Continuation of benefits while the MCO, PIHP or PAHP appeal and the state Fair Hearing are pending	75.0%	75.0%	75.0%	100%	81.3%
G10	§438.424 – Effectuation of reversed appeal resolution	66.7%	100%	100%	100%	91.7%

Appendix D: NAV Methodology

Methodology

Comagine Health performed the validation of network adequacy June – October 2025. The review was based on the third submission of the provider network data files as of July 1, due the last working day of July 2025. The review assessed the activity requirements as outlined in §438.68.

Given the state enrolls American Indians and Alaska Natives in an MCP, PIHP or PAHP, the review also considered the provisions set forth in §438.14(b)(1). In addition, the review assessed each MCP provider network against MHD's 2025 Provider Network Adequacy Standards and contractual requirements.

Technical Methods of Data Collection

To ensure network adequacy, Comagine Health completed a comprehensive validation process for each MCP following the process outlined in *CMS Protocol 4. Validation of Network Adequacy*. This protocol involves six distinct activities, which are categorized into three phases:

Planning Phase:

- **Activity 1: Scope Definition** – During this initial step, Comagine Health and MHD agreed on the standards to be validated, specifically what is included and excluded in the scope and validation process.
- **Activity 2: Data Source Identification** – Comagine Health confirmed that all relevant data sources needed for validation were identified and utilized, specifically enrollee and provider data.

Analysis Phase:

- **Activity 3: Information Systems Review** – The MCP's membership, enrollment and provider information systems were reviewed as part of their HEDIS® Compliance Audits™. Comagine Health reviewed the HEDIS compliance audit FARs for membership, enrollment and provider systems. The HEDIS compliance audit includes an overall assessment of the capability of the MCP's information systems to capture and process the information required for reporting data. See the Information System Capabilities Assessment (ISCA) section for additional information on the HEDIS audit and FARs.
- **Activity 4: Data, Methods and Results Validation** – Comagine Health completed an assessment of the information, data and methods utilized by the MCP and MHD to produce the provider network data which are submitted to MHD. MHD creates files for each MCP, containing statewide enrollment by ZIP code. Files are geocoded based on ZIP code only. The provider network data files and geocoded member files are provided to Quest Analytics.

MHD utilizes Quest Analytics Quest Enterprise Services network adequacy analysis software to calculate the duration of travel time and physical distance between the addresses of members and the addresses of their nearest providers for all provider categories identified in the analysis. The results are stratified and reported by MCP, as well as by county classification.

Reporting Phase:

- **Activity 5: Preliminary Findings Communication to MCPs** – Comagine Health provided initial findings to MHD and the MCP via a draft report and provided an opportunity for correcting omissions and errors.

- **Activity 6: Submission of Final Findings** – Comagine Health submitted the final validation results and report to MHD and the MCP.

Description of Data Obtained

MHD provides managed care enrollment files to Quest Analytics on a quarterly basis. The MCP submits quarterly provider network files to MHD using the specified file formats. Accuracy of the data files is the responsibility of the MCP. MHD reviews the provider data submitted by the MCPs to ensure correct formatting, as well as the appropriate provider types and counts of providers within each specialty prior to being transferred to the vendor, Quest Analytics, for analysis, reporting and public posting. The MCP has the opportunity to correct data file errors in the next quarterly submission.

Quest Analytics receives the following data from MHD:

- Managed care enrollment files generated by MHD
- Provider data including facility and ancillary files generated by the MCP

In addition to the data provided by Quest Analytics, Comagine Health collected supplemental information and documentation from each MCP to support our NAV. Each MCP completed the *MCP Network Adequacy Validation Submission Form*, as outlined in the Provider Network Adequacy Standards. This form included questions in the following key areas:

- Section 1: Provider Data Systems and Processes
- Section 2: Adherence to MO HealthNet’s American Indian/Alaska Native Provider Network Contract Requirement
- Section 3: Progress on Previous Year (2024) EQRO Recommendations

A detailed description of the methodology, data sources, data files and exceptions criteria are included in the [Missouri 2025 Provider Network Adequacy Standards](#).

Data Aggregation and Analysis

To begin the process, the MCP provides quarterly provider network data to MHD, which then passes this information to Quest Analytics. MHD runs separate quarterly files for each MCP, containing statewide enrollment by ZIP code, as of the first day of the first month, each quarter. Files are geocoded based on ZIP code only; addresses are not included in enrollment files. Geocoded member files created by MHD are provided to Quest Analytics.

MHD utilizes Quest Enterprise Services network adequacy analysis software to calculate the duration of travel time and physical distance between the addresses of members and the addresses of their nearest providers for all provider categories identified in the analysis. The results are stratified by MCP, as well as by county classification. Additional details of the methodology and data sources, including a description of Missouri counties, county classifications, provider types and specialties are provided in 2025 Provider Network Adequacy Standards.

For provider types that did not meet the access standard, exceptions will automatically be made by MHD for a county/provider type combination when all the following conditions are true:

- There are one or fewer (two or fewer for PCP and OBGYN) “market providers” practicing in the county (i.e., the county contains insufficient providers of that type, regardless of their status as enrolled Medicaid providers)
- No MCP scores 100%

- The MCP has the highest score among its competitors or is within five percentage points of the highest score attained by any MCP

Market providers include all available providers based on taxonomy code.

Manual exceptions by MHD are considered in rare cases. If needed, written documentation about the provider's unwillingness to contract with the plan or demonstration that the database of market providers is not accurate may be requested. In either case, the indicator will be marked as "met via exception" for applicable county/provider type combinations.

Scoring

Validation Ratings and Overall Score

The validation score was derived by completing protocol worksheet 4.6. Assessment of MCP Network Adequacy Data, Methods and Results. This worksheet assists in evaluating and assessing the data and methods used to calculate results for each network adequacy indicator. Additionally, it guides us in generating a validation rating that reflects the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

Calculate Validation Score and Rating

The responses to the questions in protocol 4 worksheet 4.6 were counted and the results are presented as either "Yes," "No" or "NA" based on the reviewer's evaluation of the documents submitted. Standard scores are presented as the number of "Yes" elements out of the total number of scoring questions possible excluding elements scored as "NA."

The validation rating reflects the overall confidence that acceptable methodology was used during all phases of design, data collection, analysis and interpretation of the network adequacy indicators.

Table D-1 below shows the correlation between the validation score and the validation rating used in this report.

Table D-1. NAV Determination Validation Ratings Legend.

Validation Score	Validation Rating
90% or greater	High confidence
50% to 89.9%	Moderate confidence
10% to 49.9%	Low confidence
Less than 10%	No confidence

Appendix E: CM Review Methodology

To ensure a MCP is in compliance with CM requirements in its contract with MHD, Comagine Health completed a comprehensive review of documents and clinical records provided by the MCP. The information gathered during the review helps assess the quality, access and timeliness of care provided to Medicaid beneficiaries within its CM program.

The review consisted of two components to assess compliance to CM requirements in its contract with MHD:



Compliance with Contractual Requirements (referred to in this report as Document Review) – an assessment of the MCP’s compliance with CM contractual requirements, utilizing documentation submitted for selected criteria to be reviewed.



Clinical Records Review (referred to in this report as Clinical Review) – an assessment of the MCP’s compliance with CM contractual requirements, utilizing a review of clinical records submitted for selected criteria to be reviewed.

The document review and clinical record review were conducted using review tools and reviewer guidelines developed by Comagine Health and MetaStar and approved by MHD.

Technical Methods of Data Collection

The CM review, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted May through August 2025, using the review period of Jan. 1, 2024 through Dec. 31, 2024. The review followed the guidelines from *CMS EQR Protocol 9. Conducting Focus Studies of Health Care Quality*:

- **Select the study topic(s)** – MHD identified the topic and selected three focus areas for the study. Comagine Health worked with MHD to determine process for review.
- **Define the study question(s) and variables** – Comagine Health worked with MHD to identify the specific study questions, review standards and variables, as well as a plan to conduct the study. Review standards and study questions were identified for the three focus areas. Comagine Health and MetaStar developed review tools and reviewer guidelines.
- **Collect data** – Comagine Health and MetaStar used the approved review tools and guidelines to review each component. For the document review component, a desk review included an assessment of MCP operations and practices, utilizing documentation submitted by the MCP. Interviews are held to ask clarifying questions and collect additional information necessary to assess the MCP’s compliance with contract requirements. For the clinical review component, random samples were generated for each focus area, and the members were evaluated against contract requirements. The requirements for each focus area were grouped into indicators. Data was entered into an internal database.
- **Analyze, interpret and report study results** – Collected data was analyzed. Findings include the identification of measures as either a strength, being compliant, or an opportunity for improvement. Results are reported to MHD and the MCPs. Each report covers the specific review elements and corresponding sections of 42 CFR §438, MHD’s contract with the MCP and other state regulations where applicable in compliance with §438.364. Results are reported to MHD and the MCPs.

Description of Data Obtained

Data obtained and evaluated consisted of documents and clinical records provided by the MCP are described below.

Document Review

Documents obtained and reviewed include a wide range of process-related materials depending on the area of focus such as program descriptions, program evaluations, policies and procedures, meeting minutes, desk manuals, staff training plans, data submissions, results and analysis of internal monitoring, narrative reflections on progress, reports, MCP internal tracking tools or other MCP records.

Clinical Review

Comagine Health submitted a randomly selected sample of 35 members enrolled in CM or DM, for each of the focus areas. An additional sample of 10 members who were eligible for CM, but did not enroll was evaluated for requirements related to the offering and opting out of CM.

Inclusion criteria for each focus area provided below:

- **Focus Area 1: Multiple Comorbid Conditions (MCC)**
 - All individuals who were diagnosed with at least two conditions, and received at least one initial diagnosis during CY2024. For the list of applicable diagnoses, refer to MHD MCP Contract, section 2.12.1. Member CM; subsection e. General Eligibility and Assessment for CM.
 - Members must be enrolled in CM for a minimum of 90 consecutive days.
- **Focus Area 2: Pregnancy/Obstetrics (PO)**
 - All members with a pregnancy diagnosis in CY2024
 - Members must be enrolled in CM for a minimum of 90 consecutive days.
 - Members must not be enrolled in CM prior to pregnancy.
 - Members still enrolled in MCP on delivery date or on Dec. 31, 2024, if still pregnant
- **Focus Area 3: Individuals in Foster Care, Receiving Foster Care or an Adoption Subsidy, or Other Out-of-Home Placement, referred to in this report as Foster Care [SMHK only]**
 - All foster care enrollees during CY2024 (newly enrolled and those prior to CY2024) who have been enrolled in the MCP for a minimum of 60 days.
 - Members must be enrolled in CM for a minimum of 90 consecutive days.

Member level documentation was obtained for the clinical record review including:

- Assessments
- Care plans
- Case notes
- Coordination and follow-up documentation
- Referrals
- Re-stratification criteria

Data Aggregation and Analysis

Documents and clinical records provided by the MCP were reviewed and the information and data aggregated and analyzed by the following methods.

Document Review

MCPs submitted documentation stored and reviewed in databases and using a CM review tool, aligning with federal and applicable state regulations, as well as meeting contractual requirements with MHD. The databases are standardized data collection systems which store the following information:

- Requirements (standards under review)
- Documentation of findings from organizational document review
- Customized interview questions
- Rating of compliance by standard pull
- Rationale for compliance/non-compliance
- Recommendations for the organization
- Documentation from interviews with the organization

Clinical Review

MCPs were given the option of submitting PDF copies of clinical records or allowing remote access via the MCP's electronic health record system. An internal database programmed with the selected criteria was utilized to aggregate and score indicator findings from the review.

Calculation of the Medicaid State Rate (MSR)

The MSR for a given indicator is calculated using the same-year results from the three MCPs (HB, HSH, UHC) for that specific indicator. The total number of 'met' and 'not met' records across all three MCPs is aggregated to determine the MSR.

Scoring

The document and clinical review components assessed activities for the previous calendar year and evaluated MCP's compliance with the care management standards set forth in its contract with MHD. The components were scored by the following methods.

Document Review

Each CM standard has a specified number of scoring elements, which correlate with MHD contract requirements. Scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 9.

Clinical Review

Several of the indicator tables highlight the findings of non-compliance, or the "not met rationale." Identifying the specific areas of non-compliance allows the plans to focus efforts on the most common areas of weakness in CM practices, which will have the greatest impact on improvement efforts. For indicator tables that include a count, this is a count of the reasons for non-compliance, meaning a lower count equals stronger CM practices.

Refer to the legend below for scoring.

Scoring Legend

- **Strength** = rate at or above 86.0%
- **Compliant** = rate between 80/0% and 85.9%
- **Opportunity for improvement** = indicator rate at or below 79.9%

The following definitions are used to determine compliance for each scoring element.

Compliant (Fully Met):

- All policies, procedures and practices were aligned to meet the requirements

Not Compliant (Not Met):

- The MCP met the requirements in practice but lacked written policies or procedures
- The organization had not finalized or implemented draft policies
- Monitoring had not been sufficient to ensure effectiveness of policies, procedures and practices

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

Appendix F: PA Audit Methodology

To ensure MCP compliance with PA requirements in its contract with MHD, Comagine Health completed an extensive review of documents and clinical records provided by the MCPs between April and October 2025. The comprehensive nature of the information collected during the audit enabled a thorough assessment centered on the quality and timeliness of PA denial determinations that prevented Medicaid beneficiary access to care.

The program was structured around two main audit categories, process and criteria, and conducted using review tools and guidelines developed by Comagine Health and approved by MHD. These categories were further subdivided into three focus areas.



Process Audit – An assessment of MCP adherence to timeliness standards and correspondence requirements. The associated focus areas were:

- **Focus Area 1:** Timeliness Standards



Criteria Audit – An assessment of MCP compliance with documented practices related to medical necessity or clinical guideline selection and application, and their adherence to denial rationale documentation requirements. The associated focus areas were:

- **Focus Area 2:** Selection and Application of Medical Necessity Criteria/Clinical Guidelines
- **Focus Area 3:** Rationale in Denial Determination

Technical Methods of Data Collection

The PA audit, a combined effort by clinical and non-clinical staff and subject matter experts, spanned the months of April through October 2025, using the review period of Jan. 1, 2024, through Dec. 31, 2024. The review followed the guidelines from *CMS EQR Protocol 9. Conducting Focus Studies of Health Care Quality*:

Select the study topic – MHD identified the general topic: PAs, with denial determinations rendered between Jan. 1, 2024, through Dec. 31, 2024, that prevented access to care. Two audit categories were selected for the study: process audit and criteria audit.

Define the study question(s) and variable(s) – Comagine Health, with approval from MHD:

- Identified audit Pass/Not-Pass criteria,
- Developed study questions, audit tools and guidelines,
- Drafted audit plan, and
- Established audit timeline.

Develop a plan to study the population – The audit program, in collaboration with MHD, was designed by Comagine Health. The intent was to establish a baseline representation of MCP PA practices.

Collect data – Using MHD's 'Prior - Authorization and Denials Log', a statistically significant random sample of MCP denied PAs was generated by Comagine Health's data analytics team. Comagine Health used the approved review tools and guidelines to complete the audits. Data was captured in Comagine Health's care management software system.

Analyze and interpret study results – Collected data was analyzed. Findings include the calculation of Pass and Not-Pass incidence, identification of strengths, weaknesses and opportunities for improvement, and recommendations.

Report results – Results were reported to MHD and the MCPs.

Description of Data Obtained

Data obtained and evaluated consisted of records provided by MCPs, as listed below.

1. Medical Records
 - a. Medical records submitted with original PA request
 - b. Medical records submitted in response to a request for additional information, when applicable
 - c. Medical records submitted with extension request, when applicable
2. Correspondence
 - a. Letter(s) requesting more information
 - b. Letter(s) communicating denial determination to member and provider
3. Medical Necessity Criteria/Clinical Guidelines
 - a. Clinical Reviewer documentation summarizing initial clinical review
 - b. Copy of (if not available for public access), or reference to (if readily accessible to public), medical necessity criteria/clinical guideline applied
4. Data elements showing workflow progression (abstract/internal notes from MCP software system)
 - a. Date, time and mode (phone, fax, email, electronic – provider portal) of PA request submission by provider
 - i. Decision Timeframe Designation: Routine vs Urgent
 - ii. Requesting/Treating Provider Name and National Provider Identifier (NPI)
 - iii. Admitting (Place of Service) Provider Name and NPI
 - b. Request for Additional Information: Date and time **MCP** requested additional information from the requesting provider, if applicable
 - i. Date and Time additional information was received
 - c. Extended Review Requested: Date and time **MCP** requested, if applicable
 - i. Date and Time additional information was received
 - d. Extended Review Requested: Date and time **Member** requested, if applicable
 - i. Date and Time additional information was received
 - e. Extended Review Requested: Date and time **Provider** requested, if applicable
 - i. Date and Time additional information was received
 - f. Date and time PA request was **sent** to MCP physician for review
 - i. Date and Time PA request was **reviewed** by MCP physician
 - ii. MCP physician care management system ID number or name
 - iii. MCP physician review notes/decision rationale
 - g. Date and time P2P conversation was **offered**
 - i. Date and Time requesting provider relayed intent to engage in P2P conversation, if applicable
 - ii. Date and Time P2P conversation **occurred**, if applicable
 - iii. MCP physician care management system ID number or name, if P2P conversation occurred

- iv. MCP physician review notes/decision rationale, if P2P conversation occurred
- v. Name and NPI of requesting provider who engaged in P2P, if P2P conversation occurred
- h. Date and time MCP physician rendered denial determination
 - i. MCP physician care management system ID number or name
- i. Date, time and distribution mode of denial letter sent to member
- j. Date, time and distribution mode of denial letter sent to requesting provider

Data Aggregation and Analysis

For each audited record, a case was established in Comagine Health's care management software system. Documents supplied by MCPs in response to audit requests were saved to the applicable case in this system and reviewed for criteria elements indicating whether the MCP met state requirements when conducting their initial PA review. These criteria elements were documented in an assessment attached to the audit case.

To ensure data integrity, data validation tools were constructed to identify and address any inaccuracies recorded in the care management software system. Peer reviews were also conducted regularly to ensure consistency in the audit process and in data entry by clinical and non-clinical staff.

Upon completion of all audits, data was extracted to Microsoft SQL Server and Excel for further validation, aggregation and analysis. Results were reviewed at the program, MCP, focus area, and criteria element levels to understand overall performance and identify driving factors leading to Not-Pass conclusions. The data aggregation formulas and methods were peer reviewed for accuracy and then strengths, weaknesses/opportunities for improvement, and recommendations were developed.

Audit Pass/Not-Pass Criteria

The Pass/Not-Pass criteria were incorporated into an assessment tool (see the [2025 Prior Authorization Audit Program Report](#)) and are based on answers to the following questions:

1. Did the auditor determine that MCP applied appropriate criteria set?
 MCP Contract Section 2.6.5 Prior Authorization includes the requirement that there is a set of written criteria for review based on sound medical evidence that is updated regularly and consistently applied.
 During the preparation phase of the audit, MCPs submitted information about their medical necessity criteria/clinical guideline application practices. This question assesses compliance with the MCP stated procedures.
2. Was the denial determination supported by clinical rationale (clear and precise member-specific reasoning)?
 MCP Contract Section 2.6.5 Prior Authorization includes the following requirements:
 - All denials, reconsideration requests, and appeals must be reviewed by a professional who has appropriate clinical expertise in treating the member's condition or disease, and
 - Reasons for decisions are clearly documented, and

- When the health plan makes a decision that results in denial, the health plan must notify the provider and offer an opportunity to request reconsideration.

This question seeks to validate a member-centric approach to clinically based decision-making as evidenced by denial rationale that includes:

- Reference to medical necessity criteria or clinical guidelines applied by the initial clinical reviewer, and
- The professional clinical opinion, with consideration given to the initial clinical reviewer's impressions as well as any reference materials consulted by the MCP medical director during their review, and, when indicated,
- Summation of P2P dialogue.

3. Was the decision timely?

MCP Contract Section 2.6.5 Prior Authorization includes the requirement that the review process must be completed and communicated to the provider in a timely manner. The timeliness parameters are based upon:

- The elapsed time from submission of the request for PA until the MCP determination to deny requested service(s) was communicated to the requesting provider, and
- The categorization of the PA request:
 - Expedited/Urgent, or
 - Routine/Non-Urgent.

Decisions for urgent requests must be made within 24 hours and routine within 36 hours, including one business day. These timeframes may be extended under certain circumstances:

- When the MCP seeks additional information from the requesting provider, the decision timeframe may be extended to 14 days, or
- When a formal extension request is submitted by the provider, member or MCP, and approved by MHD, up to an additional 14 days may be permitted.

Scoring

The process and criteria audit components assessed activities for the previous calendar year and evaluated MCP compliance with the PA standards set forth in its contract with MHD. The audit Pass/Not-Pass criteria elements were scored employing the following thresholds:

≥ 90% = Pass

< 90% = Not-Pass

To register as a 'Pass' score, a record must receive the designation of 'Yes' in response to all five questions posed in the audit Pass/Not-Pass criteria. The percentage was calculated by the number of records that received a 'Pass' score representing the numerator, and the total number of records reviewed during the audit serving the denominator.

Strengths, weaknesses/opportunities for improvement, and recommendations are provided based on audit results.

'Strengths' are defined as areas that scored at or above 90%. 'Weaknesses/opportunities for improvement' are included for any area that scored below 90%. For Not-Pass findings, the EQR team also included information about missing requirements.

Appendix G: Recommendations and Tracking Progress

All EQRO recommendations are compiled into a Required Action (RA), formerly known as a corrective action plan and issued to the MCP along with the final report. The MCP must submit the RA to MHD and Comagine Health, detailing how the MCP will address the recommendations. The response is to be submitted within 10 business days of receipt of the RA and should specifically address the weaknesses/opportunities for improvement listed for each standard and referenced element, if applicable. The response should include, but is not limited to:

- Timeline proposed for the MCP to satisfactorily address the recommendation
- Document(s) that will be updated, if applicable, and how the MCP will ensure revisions will be made in a timely manner
- Processes the MCP plans to implement to address the recommendation and how the MCP will evaluate these processes
- Individual(s) responsible for ensuring the completion of the RA recommendation

Once the RA is deemed satisfactory, it will be approved by Comagine Health in consultation with MHD. For RAs that can be quickly implemented (e.g., policy updates), the MCP is required to submit a detailed narrative, including evidence of the steps taken, within 90 days of approval.

The annual technical report will include a section for progress on the prior year's EQRO recommendations for each activity reviewed. This section is a summary of the RA recommendations, actions taken by the MCP and degree to which the plan addressed the recommendations from the prior review. Progress is evaluated based on the number of recommendations accepted and met by the MCP through the RA process.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **High** – All recommendations accepted and met
- **Medium** – Less than all recommendations accepted and met
- **Low** – No recommendations accepted and met
- **NA** – No recommendations received

Additionally, recommendations are presented to MHD at the aggregate program level (MO). While RAs are not provided to MHD, a response outlining the actions taken to address these recommendations is submitted to Comagine Health for inclusion in the following year's annual technical report.